

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4166 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2 Film G263 5/11/60 iwk

04069

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>AA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel Res. 1318 Eye St. S.W.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Little Pertuxent River</b>		d. STREET ADDRESS <b>Children's Center</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Curtis Leo Allen</b>		4. DATE OF DEATH Month Day Year <b>Found dead April 30th. 19 60</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/22/51</b>
9. AGE (In years last birthday) <b>8</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington D.C.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Roscoe Allen</b>		14. MOTHER'S MAIDEN NAME <b>Mamie Hackett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Cjildren's Center Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Accidental Drowning</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>929.8</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mental retardation</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Was found drowned in the little Pertuxent River.</b>	
20c. TIME OF INJURY Month, Day, Year <b>Unknown 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Little Pertuxent River, Laurel, A.A.</b>		20f. (City or town) (County) (State) <b>Maryland.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Gustave H. Faubert</b>		DATE SIGNED <b>4/30/60</b>	
EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/4/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Washington D.C.</b>	22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry W. Joyner</b>		24. REC'D BY REGISTRAR <b>DATE MAY 6 '60</b>	
ADDRESS <b>116 11th Ave. Washington D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Kenna</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used for a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



4167

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY		✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel, Maryland</b>		c. LENGTH OF STAY IN 1b <b>11/3/33</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b>		47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>District Training School, Children's Center</b>				d. STREET ADDRESS <b>730 Hobart Place N.W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Richard</b>		Middle <b>Allen</b>		Last <b>Allen</b>	
4. DATE OF DEATH		Month <b>April</b>		Day <b>13</b>		Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 23, 1930</b>		9. AGE (In years last birthday) <b>29</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Institutionalized</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Oliver Allen</b>				14. MOTHER'S MAIDEN NAME <b>Louise Edwards</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>--</b>		INFORMANT <b>District Training School, Children's Center, Laurel, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART DISEASE</b> <b>758.6</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>MARFAN'S SYNDROME</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mental Retardation</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>--</b>					
20c. TIME OF INJURY Hour <b>o. m.</b> <b>p. m.</b> Month <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>--</b>		20f. (City or town) (County) (State) <b>--</b>	
21. I certify that I attended the deceased from <b>October</b> , 19 <b>54</b> , to <b>April 13</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>4/13/60</b> , 19 <b>60</b> , and that death occurred at <b>12:35</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Laurel, Md.</b> DATE SIGNED <b>4/13/60</b>							
ACTUAL SIGNATURE <b>Margaret Wong Mola</b>		M.D. <b>Medical Officer, Children's Center</b>					
PHYSICIAN'S NAME (Type) <b>Margaret Wong Mola, M.D.</b>		<b>Laurel, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 15, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>District Training School</b>		22d. LOCATION (City, town, or county) (State) <b>Laurel, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. S. S. S.</b>		ADDRESS <b>District Training School</b>		24b. REC'D BY REGISTRAR <b>APR 18 '60</b>		24c. REGISTRAR'S SIGNATURE <b>Wm. S. S. S.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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758.6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4168 CERTIFICATE OF DEATH

64071

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN lb 13 years 4mo. 13 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3 Vol. 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 1909 N. Fulton Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Cas Alston				4. DATE OF DEATH Month Day Year 4 26 19 60			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH May 15, 1910	
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME Al Alston				14. MOTHER'S MAIDEN NAME Minerva ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Thrombosis (c) Arteriosclerotic Cardiovascular Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epilepsy INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/13 1946 to 4/26 1960, that (I) (we) last saw the deceased alive on 4/26 1960, and that death occurred at 8:45 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Hildegard Heard Reissman				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4/26/60	
22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D.				22d. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/30/60		23c. NAME OF CEMETERY OR CREMATORY Arboretum Park		23d. LOCATION (City, town, or county) (State) Baltimore Md	
24. FUNERAL DIRECTOR'S SIGNATURE Charles G. Cooper				ADDRESS 500 E. Lexington Ave		25a. REC'D BY REGISTRAR DATE MAY 6 '60	
						25b. REGISTRAR'S SIGNATURE Charles G. Cooper	

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may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4169 CERTIFICATE OF DEATH 64072

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>				c. LENGTH OF STAY IN 1b <b>12 yrs. 6 mo. 19 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle Last <b>Artis</b>				4. DATE OF DEATH Month <b>4</b> Day <b>30</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 7, 1901</b>	
9. AGE (In years last birthday) <b>58</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard Flowers</b>				14. MOTHER'S MAIDEN NAME <b>Mary</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Capillary Glomerulosclerosis</b> DUE TO (c) <b>Diabetes Mellitus</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Hour <b>0</b> Minute <b>0</b> Day <b>19</b> Year <b>1960</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) -----	
20f. (City or town) -----				20g. (County) -----		20h. (State) -----	
21. I certify that (I) (this hospital) attended the deceased from <b>9/5</b> <b>1960</b> , to <b>4/30</b> <b>1960</b> , that (I) (we) last saw the deceased alive on <b>4/30</b> <b>1960</b> , and that death occurred at <b>11:10 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>L. Benedict</b>				22b. DATE <b>5/2/60</b>		22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b>	
22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/5/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Mrs. F. L. Williams</b>				25a. REC'D BY REGISTRAR DATE <b>MAY 6 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

11-10-1961

UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D.C. 20250

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4170 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64073

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Solly, P.O. Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>15 days ?</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		3V01.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>In the woods, off Fort Smallwood Rd. Pennington and Filbert Streets</u>				d. STREET ADDRESS <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> , Middle <u>Eldridge</u> , Last <u>Baldwin</u>				4. DATE OF DEATH <u>Found dead</u> <u>April 15</u> Day Year <u>19 60</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/28/08</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Acetylene Burner</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Patapsco Scrap</u>		11. BIRTHPLACE (State or foreign country) <u>Prince George County</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Samuel Baldwin</u>				14. MOTHER'S MAIDEN NAME <u>Sarah E. Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-05-4087</u>		17. INFORMANT Address <u>Mrs. Ruth Baldwin, Wife, HighPoint, Pasadena, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Self inflicted wound to the head with a 12</u> <u>976 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>gauge double barrell shot gun.</u> (c) <u>Sudden</u> DUE TO (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>See #18</u>					
20c. TIME OF INJURY Month, Day, Year <u>Unknown</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Off Fort Smallwood Rd. Solly, Glen Burnie, AA, Md.</u>		20f. (City or town) (County) (State) <u>—</u> <u>—</u> <u>—</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>4/15/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/16/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kirkley, Glen Burnie, Md.</u>				24a. REC'D BY REGISTRAR <u>APR 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other information is necessary, please enclose a separate certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

10-1-1933

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

**CERTIFICATE OF DEATH**

9762

<p>1. Name of deceased: _____</p>	
<p>2. Sex: _____</p>	
<p>3. Age: _____</p>	
<p>4. Date of death: _____</p>	
<p>5. Place of death: _____</p>	
<p>6. Cause of death: _____</p>	
<p>7. Signature of attending physician: _____</p>	
<p>8. Signature of registrar: _____</p>	
<p>9. Signature of informant: _____</p>	
<p>10. Signature of medical examiner: _____</p>	
<p>11. Signature of coroner: _____</p>	
<p>12. Signature of jury: _____</p>	
<p>13. Signature of witness: _____</p>	
<p>14. Signature of funeral home: _____</p>	
<p>15. Signature of other: _____</p>	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4171

## CERTIFICATE OF DEATH

Reg. Dist. No. **4074**

1. PLACE OF DEATH a. COUNTY <b>M. A.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>M. A.</b> b. COUNTY <b>M. A.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PL. PLEASANT</b>		c. LENGTH OF STAY IN 1b <b>X</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FERRACE</b>		d. STREET ADDRESS <b>FERRACE ST.</b>	
3. NAME OF DECEASED (Type or print) <b>First Middle Last</b> <b>Elfreda HANUSIAN</b>		4. DATE OF DEATH Month <b>11</b> - Day <b>7</b> - Year <b>1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-30-95</b>
9. AGE (In years lost birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>4</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>I. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Charles Day</b>		14. MOTHER'S MAIDEN NAME <b>Hannah Belle Jones</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Family</b>	
17. INFORMANT <b>Family</b>		Address <b>None</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442X</b> DUE TO <b>Worms</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Hypertension</b> DUE TO (c) <b>Hypertensive C.V.D.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb</b> , 19 <b>60</b> to <b>7</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>7</b> , 19 <b>60</b> , and that death occurred at <b>4:30</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Henry S. [Signature]</b> M. D. <b>1101 [Signature]</b> PHYSICIAN'S NAME (Type) <b>Belknap [Signature]</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>McKeeley</b>		ADDRESS <b>130 E. [Signature]</b>	
24a. REC'D BY REGISTRAR DATE <b>APR 12 60</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

443 X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4172 CERTIFICATE OF DEATH

64075

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville, Maryland</b> c. LENGTH OF STAY IN 1b <b>1 year 7mo. 23 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1910 Cedric Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Beckham</b> Last <b>Beckham</b>		4. DATE OF DEATH Month <b>April</b> Day <b>18</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/16/1873</b>
9. AGE (In years last birthday) <b>86 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cabin Stewart</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
12. CITIZENSHIP OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>John Beckham</b>	
14. MOTHER'S MAIDEN NAME <b>Sally</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>325-30-5162</b>		17. INFORMANT <b>Medical Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Embolia of Pulmonary Artery</b> <b>023X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c) <b>Syphilis and Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>11</b> <b>p. m.</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat. while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/29</b> to <b>4/18</b> , 19 <b>60</b> , that (I) (we) lost saw the deceased alive on <b>4/18</b> 19 <b>60</b> , and that death occurred at <b>1:45 P. M.</b> from the causes and on the date stated above			
22a. SIGNATURE <b>Hildegard Heard Reissmann</b> M. D.		22b. DATE SIGNED <b>4/19/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissmann, M. D.</b>		22d. ADDRESS <b>Crownsville, Maryland</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial 4/21/60</b>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <b>MT. Calvary</b>		23d. LOCATION (City, town, or county) (State) <b>A. A. County Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph L. Rock</b> ADDRESS <b>1304 N. Central</b>		25a. REC'D BY REGISTRAR <b>APR 21 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

0-12





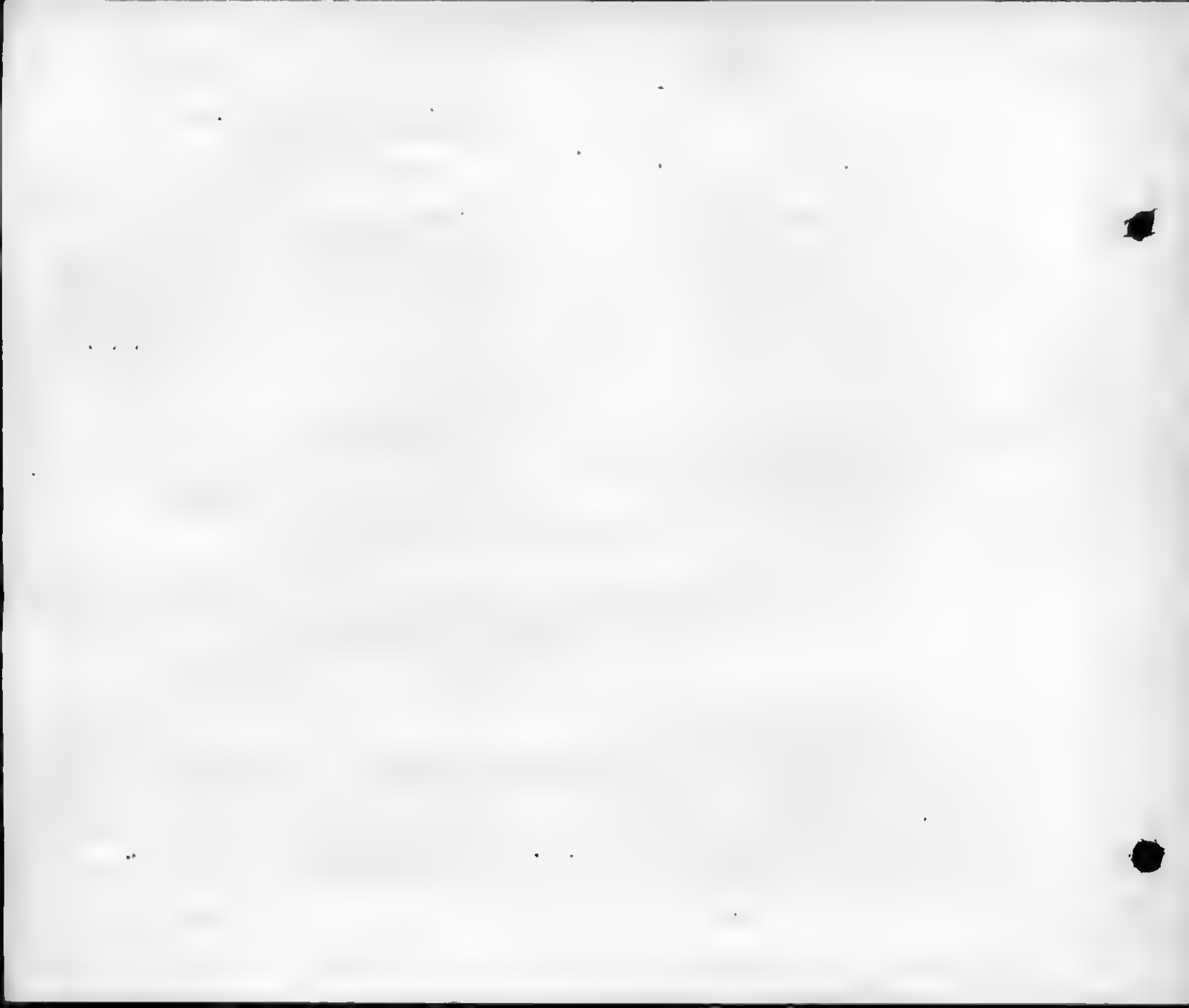
1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4173

CERTIFICATE OF DEATH

04076

1 PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN IS <b>9mo. 44 yrs 10days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>Unknown</b>			
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle Last <b>Bedford</b>				4. DATE OF DEATH Month <b>4</b> Day <b>19</b> Year <b>1960</b>			
5 SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>1880</b>		9 AGE (In years last birthday) <b>80</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>422.1</b> DUE TO <b>Arteriosclerotic Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome Associated with Arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>-----</b>					
20c. TIME OF INJURY Month, Day, Year <b>Have a m. - 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <b>-----</b>		20f. (City or town) (County) (State) <b>-----</b>	
21 I certify that (I) (this hospital) attended the deceased from <b>7/9</b> <b>1925</b> to <b>4/19</b> <b>1960</b> , that (I) (we) lost saw the deceased alive on <b>4/19</b> <b>1960</b> , and that death occurred at <b>8:15 A.</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>Hildegard Heard Reissman</i> M.D.				22b. ADDRESS <b>Crownsville State Hospital, Md.</b>		22c. DATE <b>4/19/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE THEREOF <b>April 29 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>University of Maryland</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Reese</i>				25a. REC'D BY REGISTRAR <b>APR 22 '60</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>	



4174

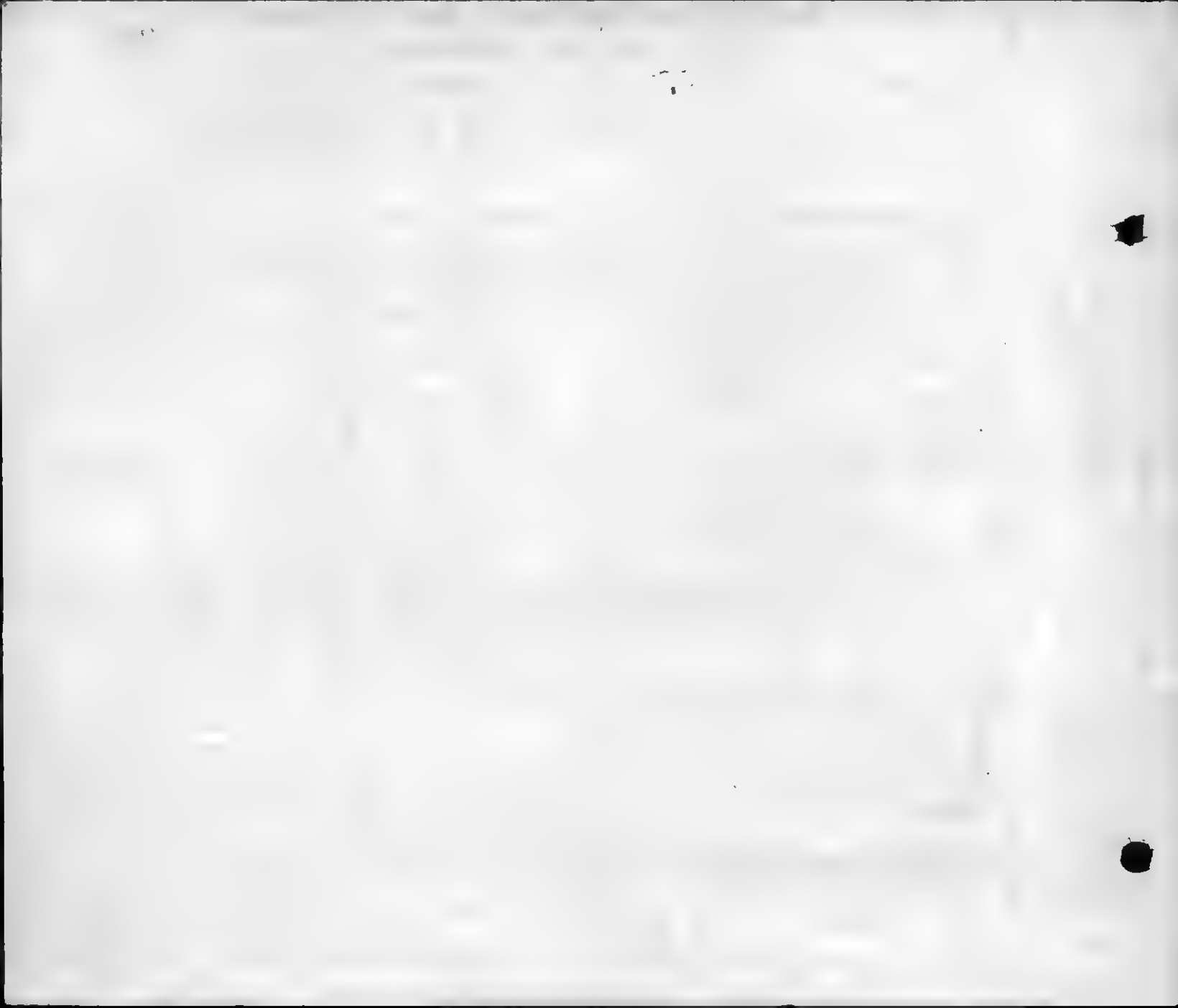
## CERTIFICATE OF DEATH

64077  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>a a</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>59</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>a a</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS		e. 15. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANK FREDERICK BENNING</u>		4. DATE OF DEATH Month Day Year <u>April 5 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 21</u>	9. AGE (in years last birthday) yrs. <u>76</u>	10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>sea food</u>		11. BIRTHPLACE (State or foreign country) <u>Shadyside Md.</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>KARL BENNING</u>			
14. MOTHER'S MAIDEN NAME <u>Louise Witt</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes 1918</u>			
16. SOCIAL SECURITY NO. <u>220303218</u>		17. INFORMANT Address <u>AGNES MAE BENNING</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO (b) <u>Arterio sclerotic heart disease</u> DUE TO (c) <u>years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Jan. 1960</u> to <u>April 5, 1960</u> , that I last saw the deceased alive on <u>March 15, 1960</u> , and that death occurred at <u>5 P</u> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Willard F. Smith</u> M.D.		ADDRESS (Street, City or town, state) <u>Shady Side, Md.</u>		DATE SIGNED <u>4/9/60</u>	
PHYSICIAN'S NAME (Type) <u>WILLARD F. SMITH, MD</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>May 8, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>2nd</u>	
22d. LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty Salisbury Md.</u>			
24a. REC'D BY REGISTRAR DATE <u>APR 12 60</u>		24b. REGISTRAR'S SIGNATURE <u>Richard S. Smith</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4175

## CERTIFICATE OF DEATH

64078

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundle</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>11-17</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie Maryland</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>330 Ordnance Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>W.</u> Last <u>Brooks</u>		4. DATE OF DEATH Month <u>4-</u> Day <u>6-</u> Year <u>19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 2, 1874</u>
9. AGE (In years last birthday) <u>85</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>Anne Arundle County</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Brooks</u>		14. MOTHER'S MAIDEN NAME <u>Melvina H. Brooks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>No</u>	
17. INFORMANT <u>I. B. Grinage 700 Whitmore Ave</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Senility</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> DUE TO <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 10, 1959</u> to <u>April 5, 1960</u> , that I last saw the deceased alive on <u>April 5, 1960</u> , and that death occurred at <u>7 AM</u> M, from the causes and on the date stated above			
ACTUAL SIGNATURE <u>P. J. Grimaldi M.D.</u>		DATE SIGNED <u>4604 Gov. Ritchie Highway</u>	
PHYSICIAN'S NAME (Type) <u>P. J. GRIMALDI</u>		<u>Baltimore 15 A.G. Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-8-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Memorial Park</u>	22d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clay O. Wilson</u>		24a. REC'D BY REGISTRAR DATE <u>APR 12 '60</u>	
ADDRESS <u>1000 Cranley Ave</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kross</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## 4176 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Q.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROOKLYN</u>		c. LENGTH OF STAY IN 1b <u>Brooklyn</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>3241 4th St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>E</u> Last <u>BROWN</u>		4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 21-1896</u>
9. AGE (In years last birthday) <u>63</u> yrs		10. UNDER 1 YEAR IF UNDER 24 HRS. Months <u>6</u> Days <u>1</u> Hours <u>1</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bld.</u>	
11. BIRTHPLACE (State or foreign country) <u>Q.C. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Brown</u>		14. MOTHER'S MAIDEN NAME <u>Ellice Wilson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(if yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO <u>Louise P. Brown</u>	
17. INFORMANT <u>Louise P. Brown</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA LUNG</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour <u>19</u> Month <u>19</u> Day <u>19</u> Year <u>1960</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4/16</u> , 19 <u>60</u> , to <u>4/28</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/28</u> , 19 <u>60</u> , and that death occurred at <u>7 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5010 N. Holston Rd.</u> DATE SIGNED <u>4/28/60</u>			
ACTUAL SIGNATURE <u>BENJAMIN BERDAN</u>		M.D. <u>5010 N. Holston Rd.</u>	
PHYSICIAN'S NAME (Type) <u>BENJAMIN BERDAN</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-30-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Riches Highway Q.C. Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 2 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4129

## CERTIFICATE OF DEATH

64080

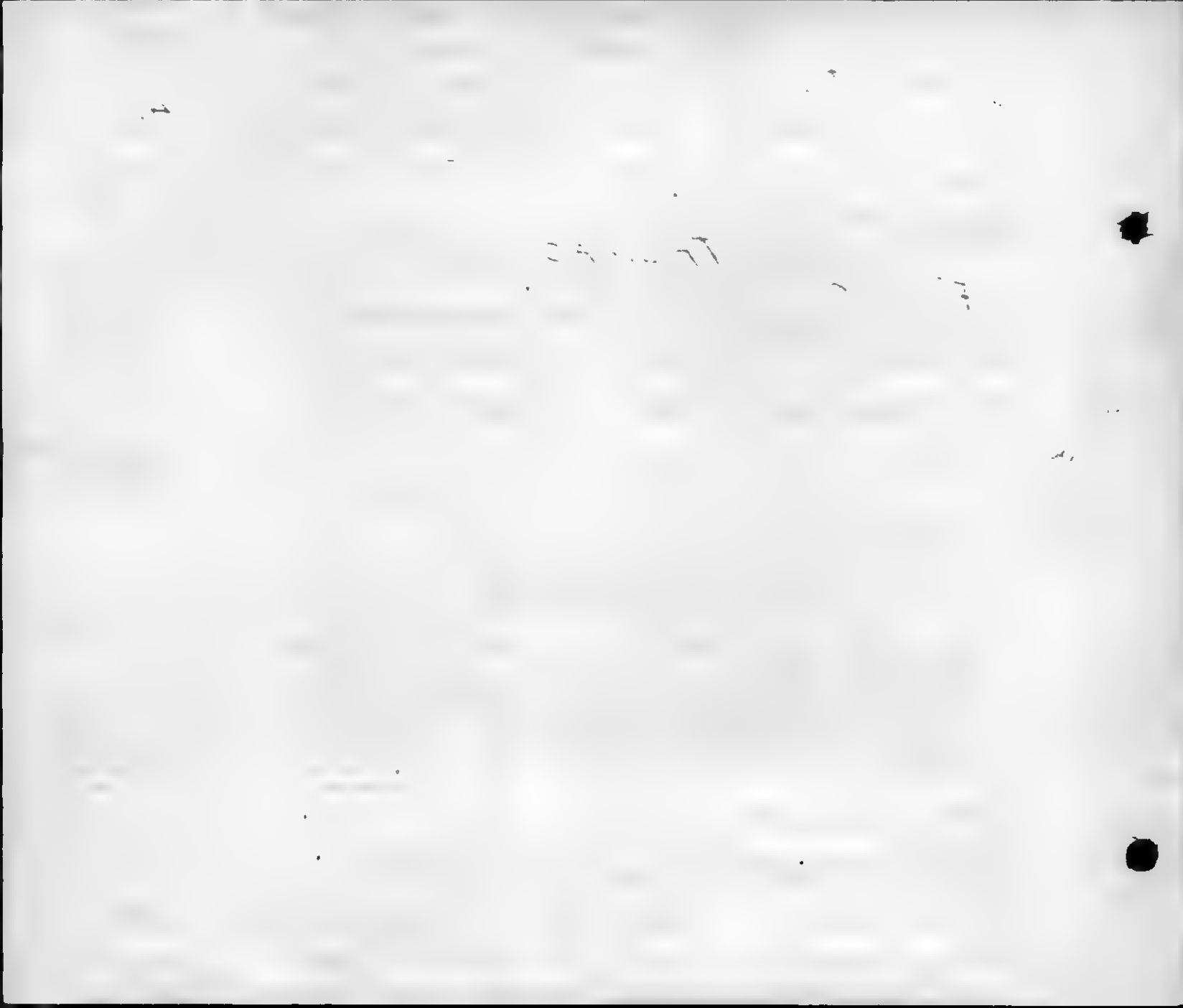
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY A.A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS 10			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION (Dead on arrival) Anne Arundel General Hospital				d. STREET ADDRESS 807 Carrollton Ave			
3. NAME OF DECEASED (Type or print) First Middle Last Margaret THOMAS BROWN				4. DATE OF DEATH Month Day Year April 26 1960			
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY-13-1906	9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ANNAPOLIS-Md	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Solomon P. Thomas				14. MOTHER'S MAIDEN NAME ELLA Kimble			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No				16. SOCIAL SECURITY NO. 215-14-6708			
17. INFORMANT Address ANNAPOLIS-Md				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 4/26, 1960, to 4/26, 1960, that I last saw the deceased alive on 4/26, 1960, and that death occurred at 9:40 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 71 Franklin St., Annapolis, Md.				DATE SIGNED 4/27/60			
ACTUAL SIGNATURE Edward S. Beck M.D.							
PHYSICIAN'S NAME (Type) Edward S. Beck							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		Apr 29-60		Brewer-Hill		ANNAPOLIS-Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Hicks III				ADDRESS ANNAPOLIS-Md.		24a. REC'D BY REGISTRAR	
						24b. REGISTRAR'S SIGNATURE	
				DATE MAY 2 '60			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

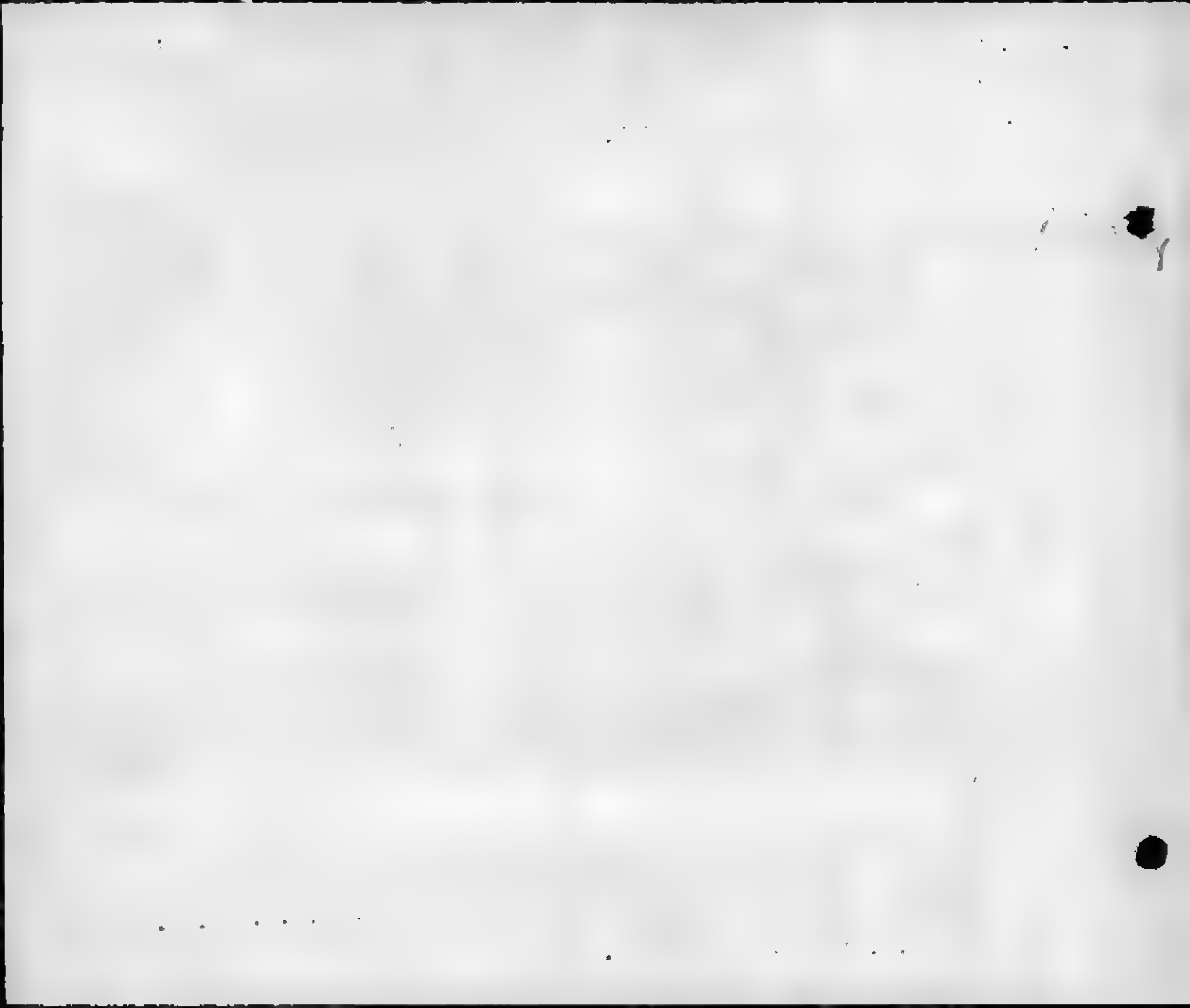
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **14081**

1. PLACE OF DEATH a. COUNTY <b>415 Forest View Rd Linthicum Heights</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Linthicum Heights</b>		c. LENGTH OF STAY IN 1b <b>30 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Marjorie</b> Middle <b>Ann</b> Last <b>Buckingham</b>		4. DATE OF DEATH Month <b>April</b> Day <b>13</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 19, 1874</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Robert Burr Tomlinson</b>		14. MOTHER'S MAIDEN NAME <b>Martha Reed</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>7111</b>	
17. INFORMANT <b>Mrs. Martha Bander</b>		Address <b>415 Forest View Rd Linthicum Hts. Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the Intestine</b> <b>159.9</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Sw</b> DUE TO (c) <b>Sw</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic valvular disease of the heart</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April</b> , 1958, to <b>April 13</b> , 1960, that I last saw the deceased alive on <b>April 12</b> , 1960, and that death occurred at <b>9:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James S. Buckingham</b> M.D.		ADDRESS (Street, city or town, state) <b>108 Cedar Ave Glen Burnie Md</b> DATE SIGNED <b>April 13, 1960</b>	
PHYSICIAN'S NAME (Type) <b>James S. Buckingham</b>		<b>108 Cedar Ave Glen Burnie Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/16/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge</b>	22d. LOCATION (City, town, or county) (State) <b>Dorsey, A.A. Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke F.D. 4101 Edmondson Ave.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 14 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Harris</b>	





TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

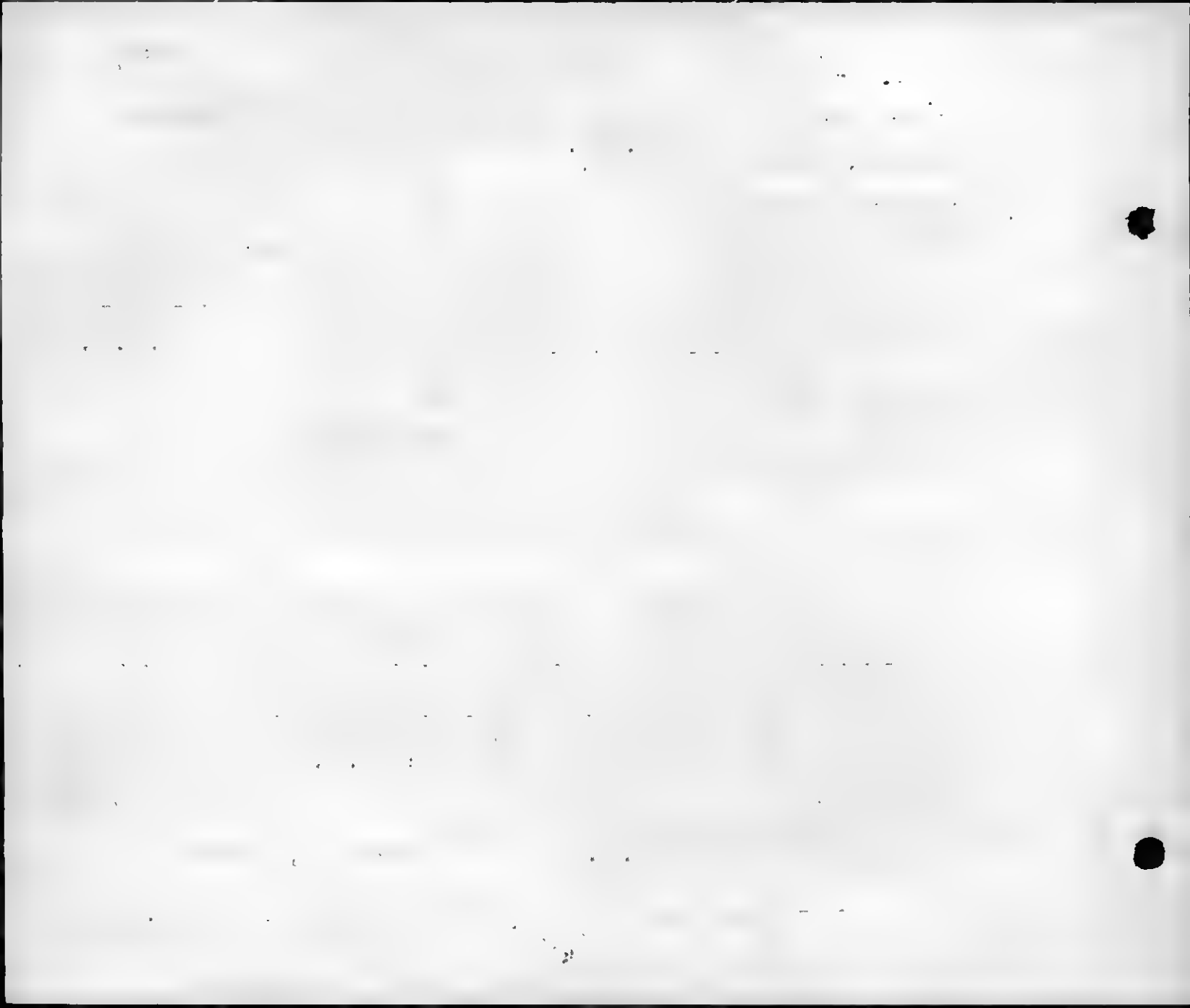
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4178 Items 8 & 9 Film 9-61 4/29/60 ink

04082

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville, Maryland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		d. STREET ADDRESS <b>Unknown</b>	
3. NAME OF DECEASED (Type or print) <b>Samuel</b> First <b>Bullock</b> Middle <b>Bullock</b> Last		4. DATE OF DEATH Month <b>April</b> Day <b>19</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1903</b> 1898
9. AGE (In years, not in days) <b>62</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Bullock</b>		14. MOTHER'S MAIDEN NAME <b>Betsy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Medical Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>023X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Syphilitic Cardiovascular Disease</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Home <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/17</b> to <b>4/19</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>4/19</b> 19 <b>60</b> , and that death occurred at <b>8:45 A. M.</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Lionel McHenry Mapp, M. D.</b>		22b. DATE SIGNED <b>4/19/60</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>Crownsville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>4-25-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wolman &amp; Schuyler</b>		25a. REC'D BY REGISTRAR <b>APR 25 60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Arnold</b>			



TO DEPARTMENT OF HEALTH, MARYLAND: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in item 18. G Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or reinterment.

# MARYLAND STATE DEPARTMENT OF HEALTH, BALTIMORE, 18

4179

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 64083

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>St. Anne's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lesonsville</u>		c. LENGTH OF STAY IN 1b <u>acute</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Anne's</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Stephen's Rd. Box 72</u>				e. STREET ADDRESS <u>St. Stephen's Rd. Box 72</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN COLIVER BURNETT</u>				4. DATE OF DEATH <u>April 14</u> 19 <u>60</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/27/59</u>		9. AGE (In years last birthday) <u>13</u> yrs. <u>15</u> Months <u>15</u> Days <u>15</u> Hours <u>15</u> Min.		10. IF UNDER 1 YEAR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Haskell Burnett</u>				14. MOTHER'S MAIDEN NAME <u>Norma Jean O'Leary</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. N. H. Burnett (mother)</u> Address <u>St. Stephen's Rd. Box 72</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Bacterial Infection</u> <u>527.2</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Charles H. Brucher MD</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4/14/60</u>	
EXAMINER'S NAME (Type) <u>Robert N. FAVBERT MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>13th April 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Ceme.</u>		22d. LOCATION (City, town, or county) <u>St. Anne's, Md.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. T. Singleton</u>				ADDRESS <u>St. Anne's, Md.</u>		24a. REC'D BY REGISTRAR <u>APR 14 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

MEDICAL CERTIFICATION

527.2

## CERTIFICATE OF DEATH

64084  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>MYRTLE</u> Middle <u>ANN</u> Last <u>CATHERTON</u>		4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 15, 1900</u>
9. AGE (in years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Frederick Md.</u>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Benjamin Griffith</u>	
14. MOTHER'S MAIDEN NAME <u>Bertha Phipps</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Vincent Catterton Bristol, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. <u>  </u> Day. <u>  </u> Year <u>  </u> Hour a. m. <u>  </u> p. m. <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3-25</u> , 19 <u>60</u> , to <u>4-2</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3-25</u> , 19 <u>60</u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Emil H. Gubin</u> M.D.		ADDRESS (Street, city or town, state) <u>Frederick, Md.</u> DATE SIGNED <u>4-22-60</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/23/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT Zion</u>	22d. LOCATION (City, town, or county) (State) <u>Lothung Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Beulah Hardaway</u>		24a. REC'D BY REGISTRAR DATE <u>APR 25 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4130

1. PLACE OF DEATH a. COUNTY <u>AN. CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ANCO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>1 1/2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BDA - Anne Arundel General</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lawrence</u> Middle <u>E.</u> Last <u>Campbell</u>		4. DATE OF DEATH Month <u>4</u> Day <u>10</u> Year <u>1960</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1.22.42</u>
9. AGE (In years last birthday) <u>18</u> yrs.		IF UNDER 1 YEAR Months <u>18</u> Days <u>10</u>	IF UNDER 24 HRS. Hours <u>10</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Ft. Meade, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas E. Campbell</u>		14. MOTHER'S MAIDEN NAME <u>Mary Joseph Kinsey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-40-2816</u>	
17. INFORMANT <u>Thomas E. Campbell</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tracheal Laceration</u> DUE TO <u>Crash by flying to chest</u> Conditions, if any, which gave rise to immediate cause (b) <u>Sudden</u> DUE TO <u>—</u> (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Tracheal wound over on subject</u>	
20c. TIME OF INJURY Month, Day, Year <u>4 10 1960</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Ft. Meade MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12 Apr. 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Our Lady of the Field Ch. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Md. 140</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Doughton</u>		ADDRESS <u>Glen Burnie, MD.</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	

MEDICAL CERTIFICATION

TO DEPT. OF HEALTH: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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## 4131 CERTIFICATE OF DEATH

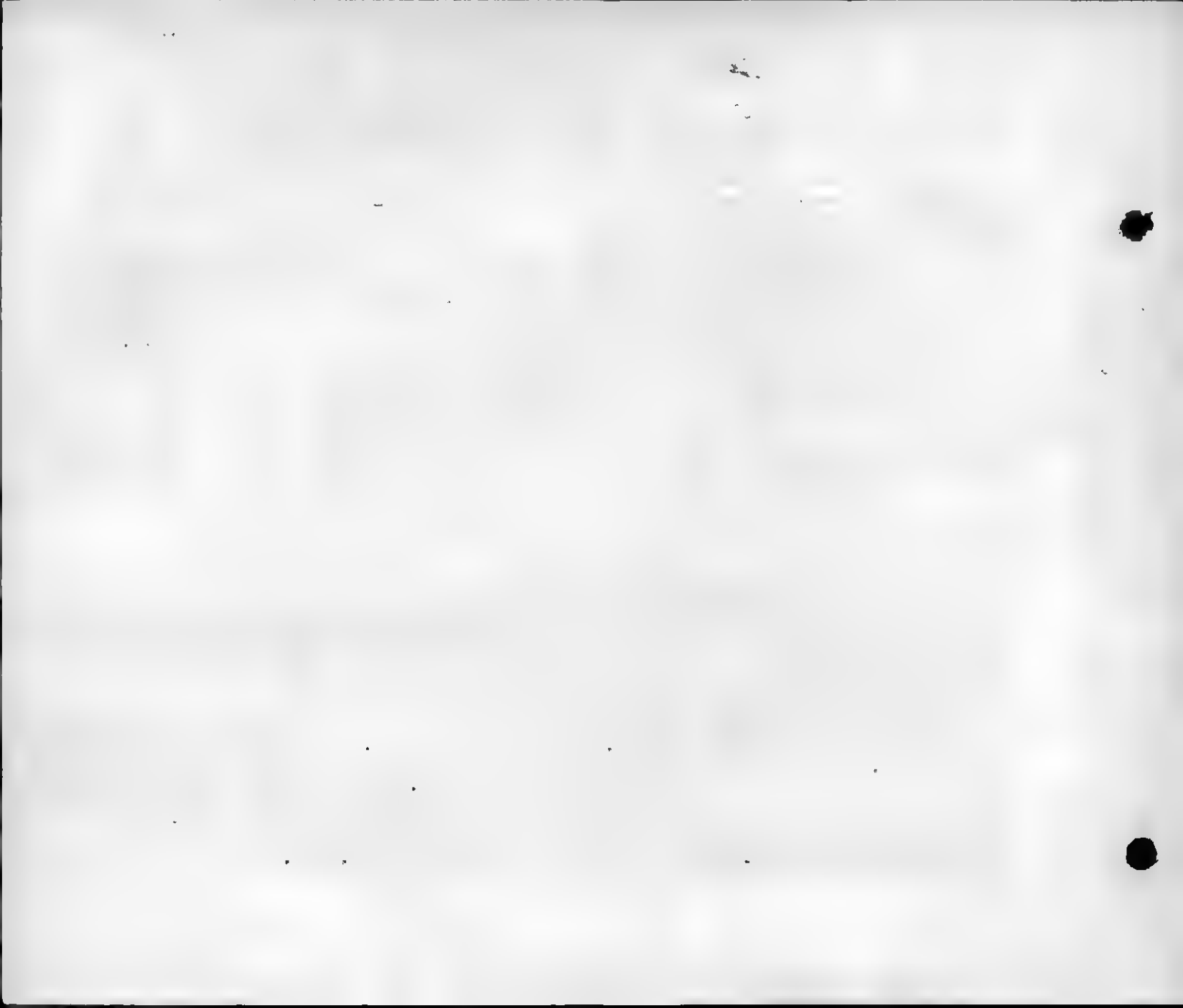
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>5 hours</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DRUSILLA</u> Middle <u>ANNE</u> Last <u>CAUDLE</u>		4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 26, 1960</u>
9. AGE (In years lost birthday) yrs. <u>5</u>		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>05</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Mervin Braxton CAUDLE</u>		14. MOTHER'S MAIDEN NAME <u>Bertamae Irene WHITING</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Hospital records</u>	
17. INFORMANT <u>Hospital records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Fire</u> (c) <u>Natal Anoxia</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>1960</u> Hour <u>o m</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Apr. 26, 1960</u> to <u>Apr. 26, 1960</u> , that I last saw the deceased alive on <u>Apr. 26, 1960</u> , and that death occurred at <u>10:05A</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clayton Norton</u> M.D.		DATE SIGNED <u>10:05A</u>	
PHYSICIAN'S NAME (Type) <u>Clayton Norton</u>		ADDRESS (Street, city or town, state) <u>Medical Building</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-2-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Private Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Nech Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		DATE <u>MAY 4 '60</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Ad.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Ad.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odenton</u>		c. LENGTH OF STAY IN It	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary Rebecca Chace</u>		4. DATE OF DEATH <u>April 12 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1 1880</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Howard Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lloyd Honey</u>		14. MOTHER'S MAIDEN NAME <u>Martha Jamis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mamie Turner</u>		Address <u>Odenton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypertensive Cardio-vascular Disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 1946</u> to <u>Apr 11 12 1960</u> , that I last saw the deceased alive on <u>Mar 28 1960</u> , and that death occurred at <u>7:15 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Edward G. Skerritt</u> M.D. <u>Lambert</u> <u>4-12-60</u> PHYSICIAN'S NAME (Type) <u>Edward G. Skerritt MD</u>			
22a. BURIAL, CREMATION, REMAINS (Specify)		22b. DATE THEREOF <u>4-16-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fork's Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Odenton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ann A. Johnson</u>		ADDRESS <u>Armadillo</u>	
24a. REC'D BY REGISTRAR <u>Apr 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

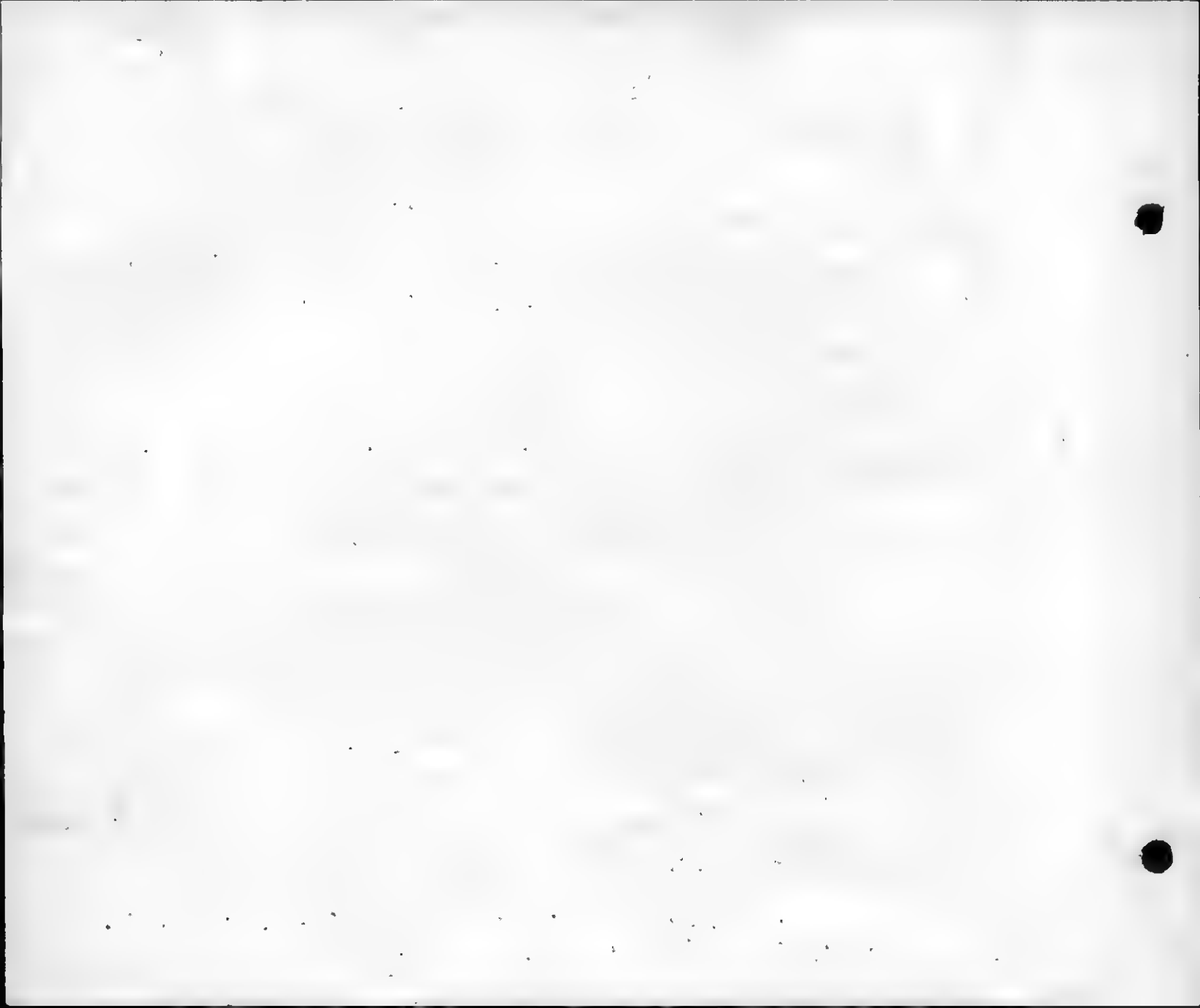
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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Thelma Avenue</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Jesse William Cogle</b>			4. DATE OF DEATH Month Day Year <b>April 21, 1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 9, 1890</b>		9. AGE (In years last birthday) <b>69</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insurance Agent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Jonathan Cogle</b>			14. MOTHER'S MAIDEN NAME <b>Lucy Derry</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b>		Address <b>Mrs. Maude Cogle Same as 2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LOBAR PNEUMONIA</b> DUE TO <b>BRONCOGENIC CARCINOMA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>BRONCOGENIC CARCINOMA</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>2 da.</b> <b>2 YRS.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o m. p m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <b>10-5</b> , 19 <b>54</b> , to <b>4-21</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>4-18</b> , 19 <b>60</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>4-22-60</b>					
ACTUAL SIGNATURE <b>Leon C. Perry</b>		M.D.			
PHYSICIAN'S NAME (Type) <b>Leon Perry, M.D.</b>					
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>25 Apr., 60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Harpers Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Harpers Ferry, W. Va.</b>		
23. HOPPING & KIRKLEY, Glen Burnie, Md.			24a. REC'D BY REGISTRAR DATE <b>APR 26 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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Item 12 Film 6261 4-20-60 et

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>33 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - Shadyside</b>	
f. STREET ADDRESS <b>Idewild</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lottie</b> Middle <b>COLE</b> Last <b>COLE</b>		4. DATE OF DEATH Month <b>April</b> Day <b>11</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 11, 1874</b>
9. AGE (In years lost birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months <b>86</b> Days <b>86</b> Hours <b>86</b> Min <b>86</b>	
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Canada TORONTO</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Gibbs</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Olive M. Shoemaker, Shadyside Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Changrene of rt. leg</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Thrombosis of popliteal artery</b> (c) <b>Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic ht. disease &amp; coronary insufficiency</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>33 days</b> <b>years</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Mar. 9, 1960</b> to <b>April 11, 1960</b> , that (I) (we) last saw the deceased alive on <b>April 11, 1960</b> , and that death occurred at <b>2:36 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Willard F. Smith</b>		22b. DATE SIGNED <b>4/12/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Willard Smith</b>		22d. ADDRESS <b>Shadyside, Md.</b>	
23a. BURIAL, CREMATON, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/13/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		23d. LOCATION (City, town, or county) (State) <b>Bladensburg Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Bernard Hardaway</b>		25a. REC'D BY REGISTRAR <b>Halverson</b>	
25b. REGISTRAR'S SIGNATURE <b>Chas. S. Thomas</b>		DATE <b>APR 14 '60</b>	

450.1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4133

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64092

Reg. Dist. No.

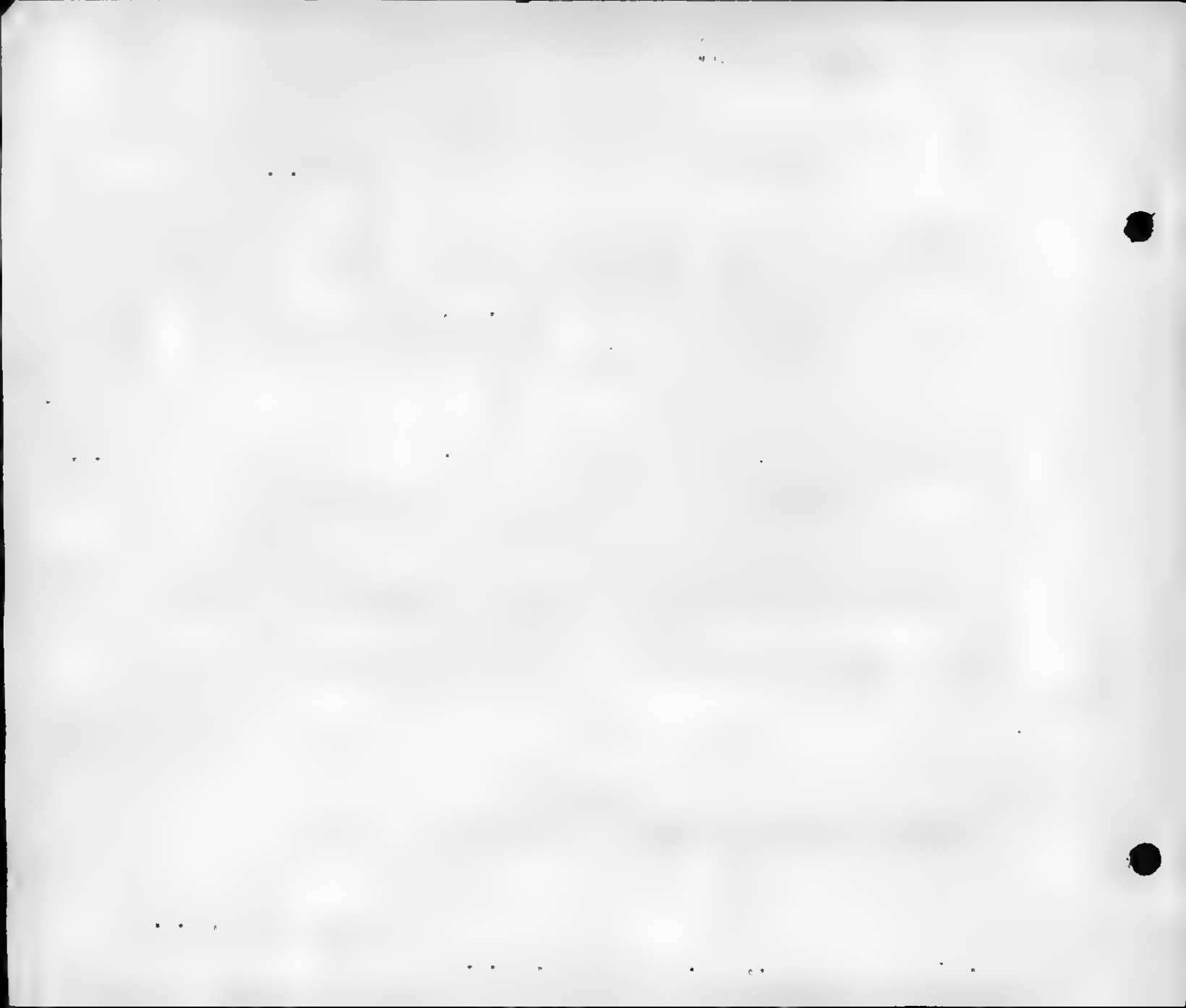
FOR STATE  
HEALTH DEPT.

Item 20 Film 262 5-1

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Washington, D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write PLGA and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN TB <u>1 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>Washington, D.C.</u>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Cox</u> Middle <u>Cox</u> Last		4. DATE OF DEATH Month <u>Apr.</u> Day <u>17</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>BSL</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 13, 1908</u>
9. AGE (in years last birthday) <u>52</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Enoch Cox</u>		14. MOTHER'S MAIDEN NAME <u>Ida Shepherd</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>  </u>	
17. INFORMANT <u>Sara R. Cox</u>		Address <u>1410 Euclid Street, N.W. #7</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental drowning</u> <u>850x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause last. DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Fell overboard from boat while boating</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>2:30</u> <u>4</u> <u>17</u> <u>19</u> <u>60</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Back Creek</u>		20f. (City or town) (County) (State) <u>Eastport, Annapolis AA Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>S. Borssuck</u> M D		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>S. Borssuck</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> acting.	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/22/1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Ernest Jarvis Co., Inc.</u> ADDRESS <u>1432 You St., N.W.</u>		24a. REC'D BY REGISTRAR <u>APR 22 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>		DATE <u>4/17/60</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

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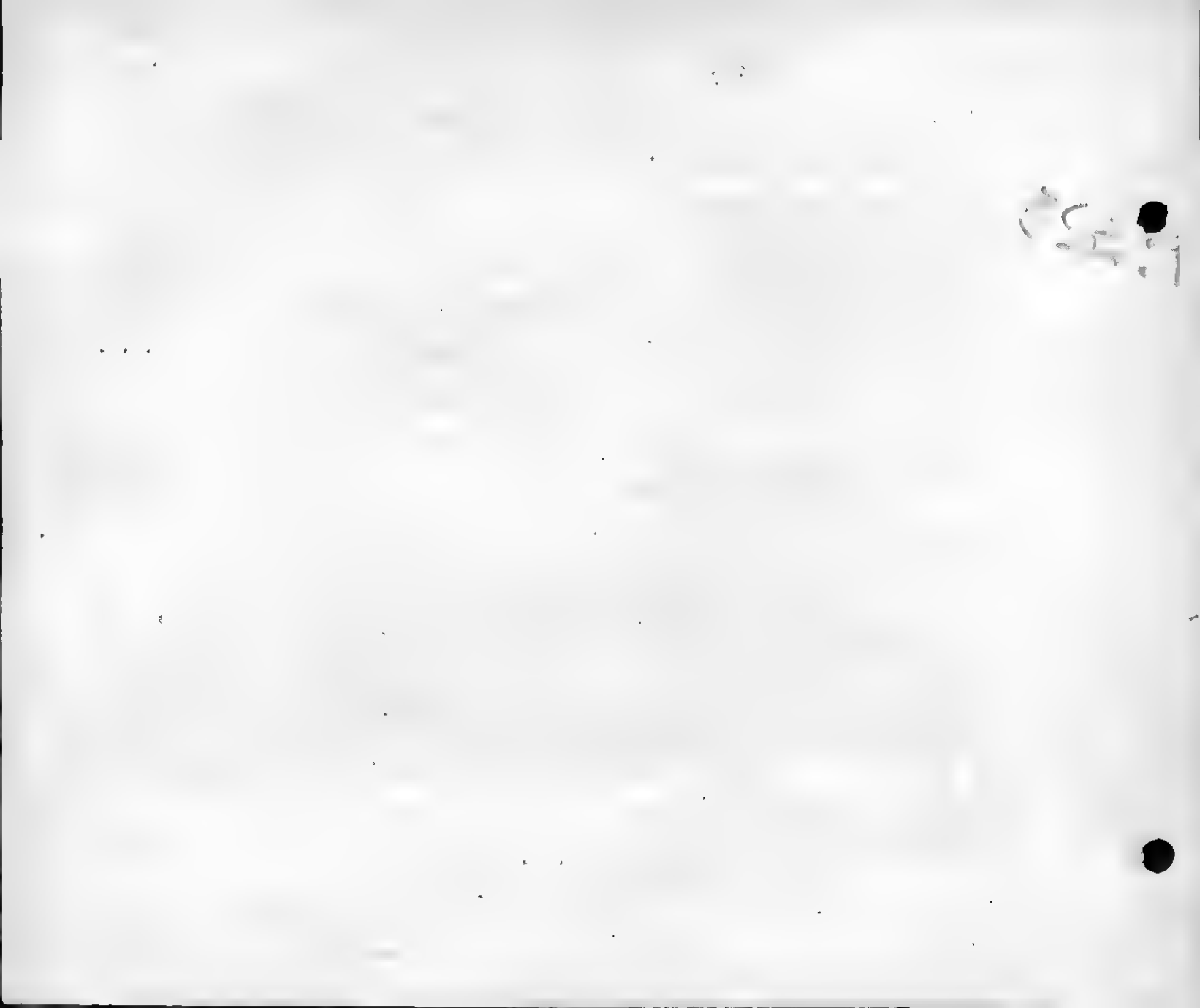
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4182

CERTIFICATE OF DEATH

64093

1 PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>2 mo. 9 days</b> d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Virginia Marie Davis</b>			4. DATE OF DEATH Month Day Year <b>4 13 19 60</b>				
5 SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 12, 1899</b>		9. AGE (In years lost birthday) yrs <b>61</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>			
13 FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17 INFORMANT <b>Hospital Records</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> <b>053.4</b> DUE TO <b>Septicemia, decubital Ulcers</b> Conditions, if any which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>since adm.</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION, GIVEN IN PART I (a) <b>Arteriosclerotic Hypertensive Cardiovascular Disease, Right Hemiparesis, Fracture of Femur</b>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>					
20c TIME OF INJURY Month, Day, Year Hour <b>m</b> - <b>p</b> m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>			
20f. (City or town) (County) (State) <b>-----</b>							
21 I certify that (I) (this hospital) attended the deceased from <b>2/4</b> 19 <b>60</b> to <b>4/13</b> 19 <b>60</b> that (I) (we) last saw the deceased alive on <b>4/13</b> 19 <b>60</b> , and that death occurred at <b>3:30 P.</b> from the causes and on the date stated above.							
22a SIGNATURE <b>Hildegard Heard Reissman</b> M.D.		22b ADDRESS <b>Hildegard Heard Reissman, M. D. Crownsville State Hospital, Maryland</b>		22c PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissman, M. D. Crownsville State Hospital, Maryland</b>			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF <b>4-18-1960</b>		23c NAME OF CEMETERY OR CREMATORY <b>Arboretum Mem. Cemetery</b>			
23d LOCATION (City, town, or county) (State) <b>Baltimore Co. Md.</b>		24 FUNERAL DIRECTOR'S SIGNATURE <b>William J. Smith</b>		25a REC'D BY REGISTRAR <b>APR 19 '60</b>			
25b REGISTRAR'S SIGNATURE <b>Carlton S. Thomas</b>							



10  
A15 (4)

## 64695

1. PLACE OF DEATH a COUNTY <b>Anne Arundel</b>		b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c LENGTH OF STAY IN 1b <b>13 years 11mo. 13days</b>		1. USUAL RESIDENCE (Where deceased lived before admission) a STATE <b>Maryland</b>		b COUNTY <b>Baltimore</b>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		d STREET ADDRESS <b>509 Orchard Street</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Frank</b>		First		Middle <b>Duppins</b>		Last		4. DATE OF DEATH Month <b>4</b> Day <b>30</b> Year <b>1960</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>1874</b>		9 AGE (In years last birthday) <b>86</b>	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS Hours _____ Min _____	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13 FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b>		Address			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]								INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Syphilitic Cardiovascular Disease</b> DUE TO (c) <b>General Paresis</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>-----</b>							
20c TIME OF INJURY Hour _____ m _____ p. m. _____		20d INJURY OCCURRED While _____ Not while _____ of work <input type="checkbox"/> at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f (City or town) <b>-----</b>		(County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>5/17</b> <b>1946</b> , to <b>4/30</b> <b>1960</b> , that (I) (we) last saw the deceased alive on <b>4/30</b> <b>1960</b> , and that death occurred at <b>A. M.</b> from the causes and on the date stated above									
22a SIGNATURE <b>[Signature]</b>		M.D.		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED <b>5/2/60</b>			
22c PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b>		22d ADDRESS <b>Crownsville State Hospital, Maryland</b>							
23a BURIAL, CREMATION, REMOVAL (Specify) <b>5/5/60</b>		23b DATE THEREOF <b>5/5/60</b>		23c NAME OF CEMETERY OR CREMATORY <b>Not Available</b>		23d LOCATION (City, town, or county) <b>Baltimore City</b>		(State)	
24 FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b>		ADDRESS <b>578 W. Biddle</b>		25a REC'D BY REGISTRAR <b>DATE 4 '60</b>		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>			





## 4134 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Braccy's</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Alfred Nicholas Easton</u>				4. DATE OF DEATH Month Day Year <u>4-30-1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 3 1895</u>	9. AGE (In years last birthday) <u>65 yrs.</u>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Alfred Easton</u>				14. MOTHER'S MAIDEN NAME <u>Annie Bonnet</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Richard Easton, Braccy, C.A. Co.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro vascular accident</u> <u>531X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertension and generalized arteriosclerosis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 20, 1960</u> , to <u>April 30, 1960</u> , that I last saw the deceased alive on <u>April 29, 1960</u> , and that death occurred at <u>6:15 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Emily H. Wilson</u>				ADDRESS (Street, city or town, state) <u>Lotman</u>		DATE SIGNED <u>4-30-60</u>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMAT. ON, REMOVAL (Specify)		22b. DATE THEREOF <u>5-3-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Way of Cross</u>		22d. LOCATION (City, town, or county) (State) <u>Sunderland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>P.E. Sewell, Prince Frederick</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 5 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be used by the hospital or attending physician.

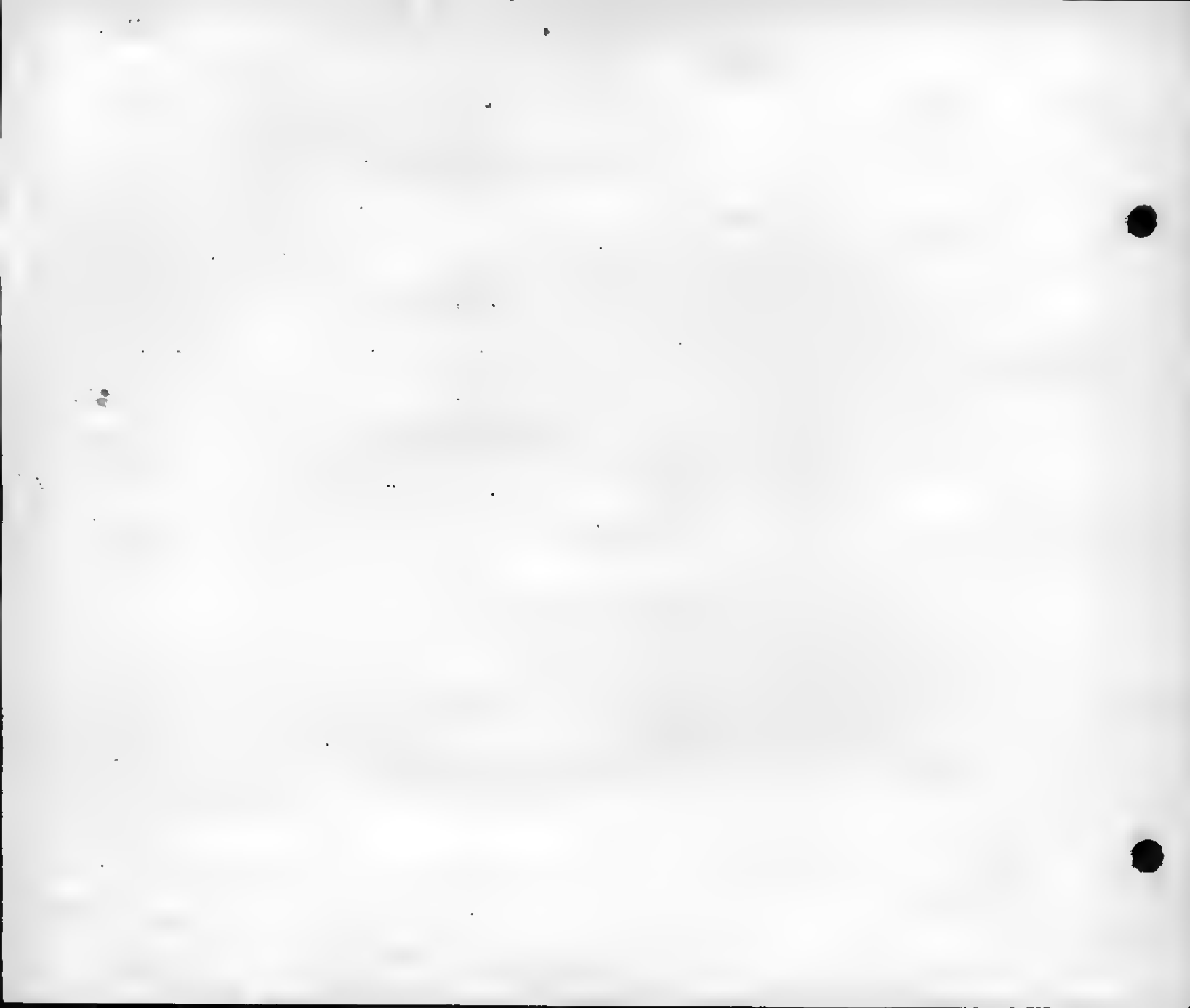
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 4184  
 CERTIFICATE OF DEATH

64097

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn Park</b>		c. LENGTH OF STAY IN 1b <b>1 hr.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4016 Ritchie Hwy.</b>		e. STREET ADDRESS <b>233 Meadow Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Kayle</b> Middle <b>Eckley</b> Last 4. DATE OF DEATH Month <b>April</b> Day <b>18</b> Year <b>1960</b>		5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>Dec. 4, 1911</b> 9. AGE (In years last birthday) <b>48</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Floor Finisher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Flooring</b>	
11. BIRTHPLACE (State or foreign country) <b>W. Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>John Eckley</b>		14. MOTHER'S MAIDEN NAME <b>Fannie</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-12-7881</b>	
17. INFORMANT <b>Mrs. Gladys Eckley</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASCVD</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hr.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 58</b> 19, to <b>Apr 60</b> 19, that (I) (we) last saw the deceased alive on <b>18 Jan 61</b> 19, and that death occurred at <b>10 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Andrew R. Sosnowski</b>		22b. DATE SIGNED <b>April 19, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Andrew R. Sosnowski M.D.</b>		22d. ADDRESS <b>4016 Ritchie Hwy. Balto. 25, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 21, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Prince George's Co., Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>George J. Ronce</b>		25a. REC'D BY REGISTRAR <b>APR 20 '60</b>	
ADDRESS <b>4001 Ritchie Hwy. Balto</b>		25b. REGISTRAR'S SIGNATURE <b>Orlando S. Kenna</b>	



## 4135 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>5 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General</u>				d. STREET ADDRESS <u>Box 15 Waterbury</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Swiant</u> First Middle Last <u>Edwards</u>				4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 29, 1960</u>	
9. AGE (In years last birthday) <u>5</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>6</u>		IF UNDER 24 HRS Hours <u>5</u> Min. <u>6</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William M. Edwards</u>				14. MOTHER'S MAIDEN NAME <u>Ila Mae Garnett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia due to</u> <u>774X</u> DUE TO <u>Neutropenic (Acute Pyelitis)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>o. m.</u> <u>p. m.</u> Month <u>19</u> Day <u>19</u> Year <u>1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 29, 1960</u> to <u>April 29, 1960</u> , that I last saw the deceased alive on <u>April 29, 1960</u> , and that death occurred at <u>2:05 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>116-CLAY STREET</u> DATE SIGNED <u>4/30/60</u> ACTUAL SIGNATURE <u>Rita Richardson</u> M.D. <u>HARVEY POLIS, M.D.</u> PHYSICIAN'S NAME (Type) <u>William Geise, Jr. - Annapolis, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-2-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>John Chesley</u>		22d. LOCATION (City, town, or county) (State) <u>Waterbury, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Geise, Jr. - Annapolis, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 3 1960</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Francis</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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may be signed by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

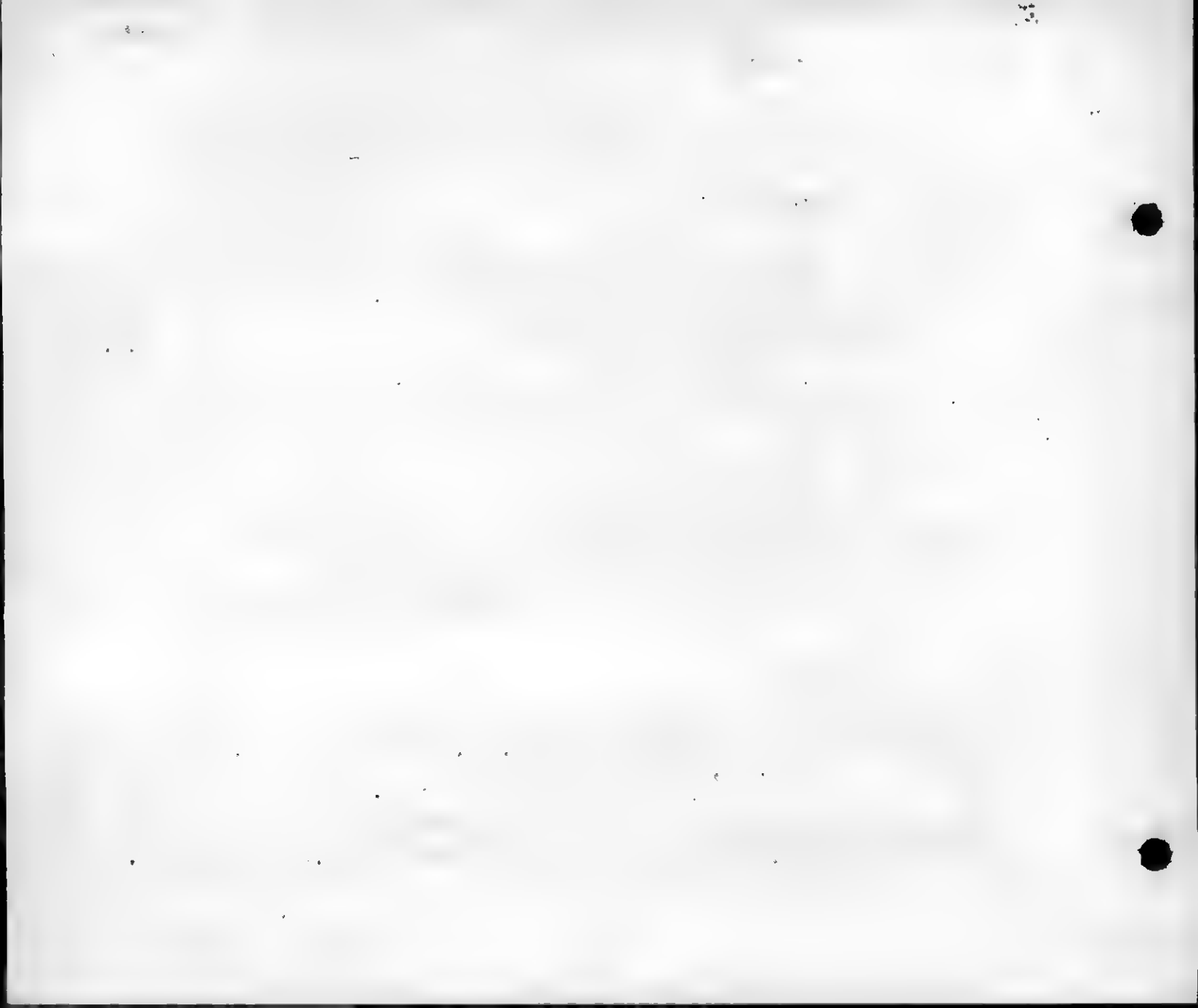
1

4136

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

64099

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>28 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				e. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>X RURAL - Owensville</b>			
				f. STREET ADDRESS		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>N.</b> Last <b>S. ELLZEY</b>				4. DATE OF DEATH Month <b>April</b> Day <b>20</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 12, 1872</b>	
9. AGE (In years last birthday) <b>88 yrs.</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>JAMES Cheston</b>				14. MOTHER'S MAIDEN NAME <b>CHARLOTTE R. STELLI</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Helen Cheston, West River Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive failure</b> DUE TO Cardiac, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>18 mos -</b> <b>30 mos -</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Mar. 23, 1960</b> to <b>April 19, 1960</b> , that (I) (we) last saw the deceased alive on <b>Apr. 19, 1960</b> , and that death occurred at <b>7:00A.</b> M. from the causes and on the date stated above.							
22a. SIGNATURE <b>Richard N. Peeler</b>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>4/20/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Richard N. Peeler</b>				22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>4/22/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Christ Church</b>		23d. LOCATION (City, town, or county) (State) <b>Owensville Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Bernard O. Hardisty, Salisbury, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>APR 25 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	





4185 CERTIFICATE OF DEATH

04160  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St Margarets</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St Margarets</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Log Inn</u>		e. STREET ADDRESS <u>Log Inn</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Silghman</u> Last <u>Emory</u>		4. DATE OF DEATH Month <u>Apr</u> Day <u>1st</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 3 1871</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hotel Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel Owner</u>	
11. BIRTHPLACE (State or foreign country) <u>Queenstown Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Blanchard Emory</u>		14. MOTHER'S MAIDEN NAME <u>Mary Bourke</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>  </u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>  </u>	
17. INFORMANT <u>Hackett W. Emory</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Vomiting, dehydration</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prob. Carcinoma of the Stomach unknown</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour a. m. <u>  </u> p. m. <u>  </u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5/5</u> 19 <u>59</u> to <u>3/19</u> 19 <u>60</u> , that I last saw the deceased alive on <u>3/19</u> 19 <u>60</u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>98 Cathedral Street</u> DATE SIGNED <u>  </u>			
ACTUAL SIGNATURE <u>Edwin Davis, Jr.</u>		M.D. <u>  </u>	
PHYSICIAN'S NAME (Type) <u>Edwin Davis, Jr., M.D.</u>		Annapolis, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr. 4-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Annes Cent</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		24a. REC'D BY REGISTRAR DATE <u>APR 6 '60</u>	
ADDRESS <u>Annapolis Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**4186** **CERTIFICATE OF DEATH**

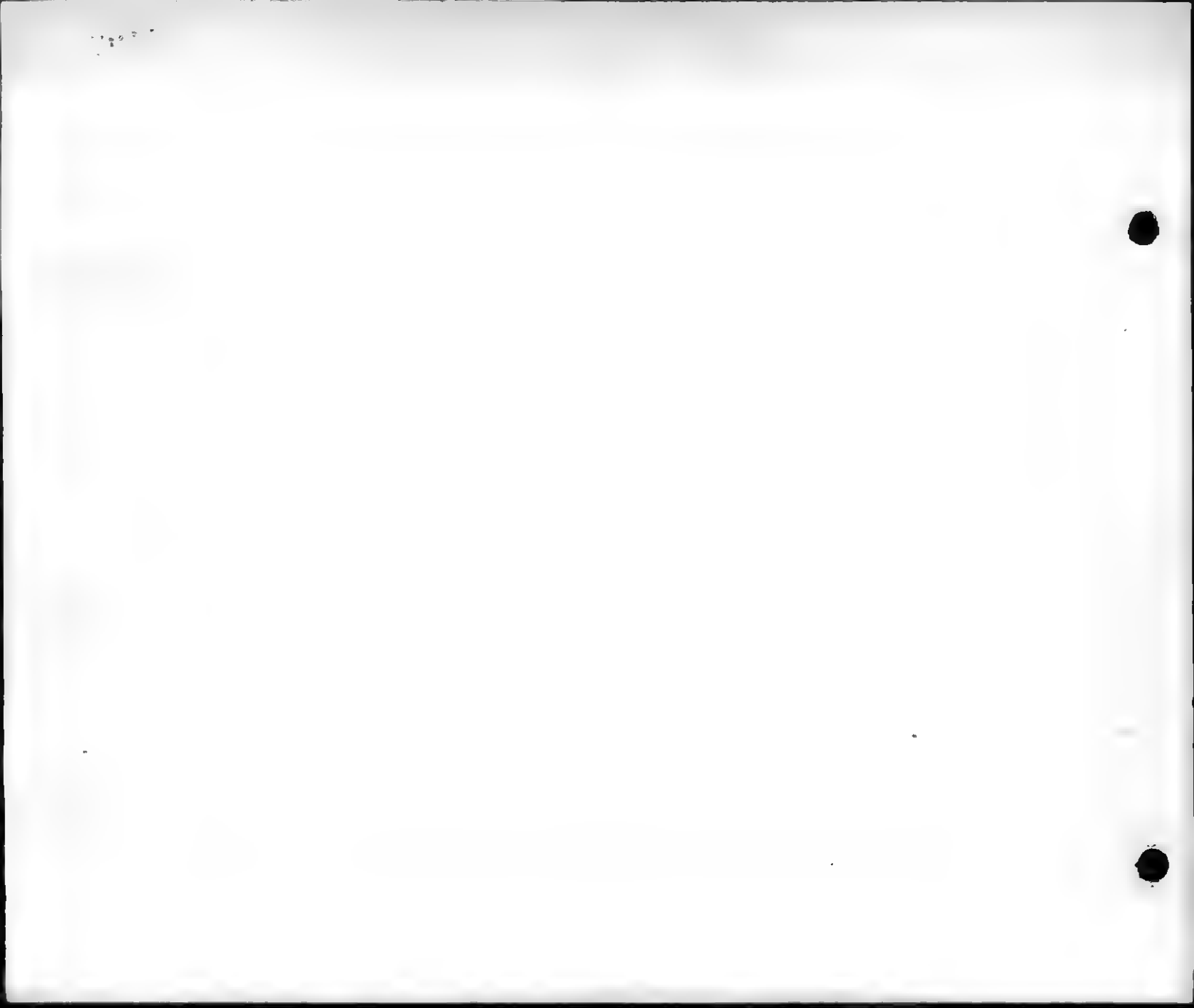
**04161**

1. NAME OF DECEASED (Type or Print) <b>Wilbur P. Erdman</b>				2. DATE OF DEATH <b>4/27/60</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <i>Kane Hospital</i> FULL NAME OF HOSPITAL OR INSTITUTION <b>Brooklyn - 25</b> <b>5210 Ballman Ave.</b>				4. USUAL RESIDENCE (Where deceased lived If institution residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>A.A. County</b> c. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Brooklyn</b> d. STREET ADDRESS (If rural, give location) <b>5210 Ballman Ave.</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>10/11/86</b>	9. AGE (In years last birthday) <b>73</b>	If Under 1 Year Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PO Carrier</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William H. Erdman</b>				14. MOTHER'S MAIDEN NAME <b>Jennie Reese</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Family</b> ADDRESS <b>Same</b>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death) <b>Acute Heart Failure - Carcinoma (Squamous) of Bladder with local metastases in the Pelvis</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 years</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II 19a. DATE OF OPERATION <b>March 1958</b> WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ex of Bladder</b> 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from <b>December 15th 1959</b> to <b>April 29, 1960</b> that (I) (we) last saw the deceased alive on <b>April 29 1960</b> and that in (my) (our) opinion death occurred at <b>5A</b> m., from the causes and on the date stated above							
23a. SIGNATURE <b>Four &amp; Glass</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M. D.		23b. ADDRESS <b>320 Patuxent St</b> <b>Balto 25, Md</b>		23c. DATE SIGNED <b>4/30/60</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>5/2/60</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill C.M.</b>		24d. LOCATION (City, town, or county) (State) <b>Brooklyn, Md.</b>	
25a. NAME OF REGISTRAR <b>William A. Gully</b>		25c. FUNERAL DIRECTOR ADDRESS <b>Gully Funeral homes 100 E. Fort Ave.</b>					

THIS IS A PERMANENT RECORD.  
INFORMATION SHOULD BE CAREFULLY SUPPLIED.  
WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY.

II CERTIFICATION

MAY 2 1960



may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

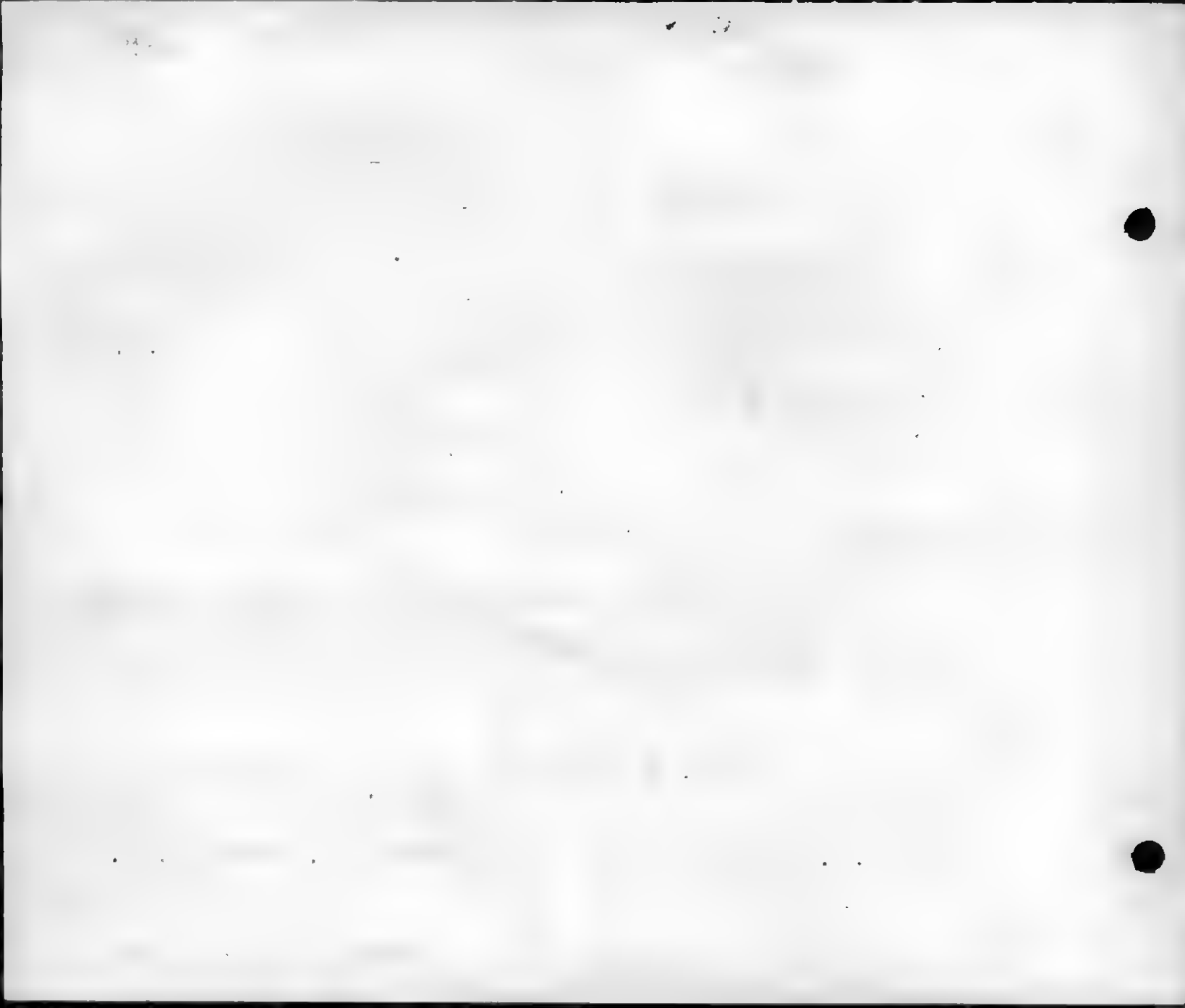
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4137

CERTIFICATE OF DEATH

64102

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>10 minutes</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - Edgewater</b>	
f. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Henry</b> Last <b>EVANS, Sr.</b>		4. DATE OF DEATH Month <b>April</b> Day <b>14</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 1, 1880</b>
9. AGE (In years last birthday) <b>80 yrs</b>		10. IF UNDER 1 YEAR Months <b>14</b> Days <b>14</b> Hours <b>14</b> Min <b>14</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WATERMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ret.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>CHARLES W. EVANS</b>		14. MOTHER'S MAIDEN NAME <b>Laura Virginia Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>217-34-9324</b>	
17. INFORMANT <b>WILLIAM H. EVANS JR.</b>		Address <b>#2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month <b>April</b> Day <b>1</b> Year <b>1959</b> Hour <b>1:35A.</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 1, 1959</b> to <b>April 14, 1960</b> , that (I) (we) last saw the deceased alive on <b>April 14, 1960</b> , and that death occurred at <b>1:35A.</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Albert L. Anderson</b>		22b. DATE SIGNED <b>4/15/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. L. ANDERSON</b>		22d. ADDRESS <b>44 Southgate Ave., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, or other disposal (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4-16-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>HILLCREST</b>		23d. LOCATION (City, town, or county) (State) <b>ANNAPOLIS MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor + Sons Annapolis, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 18 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



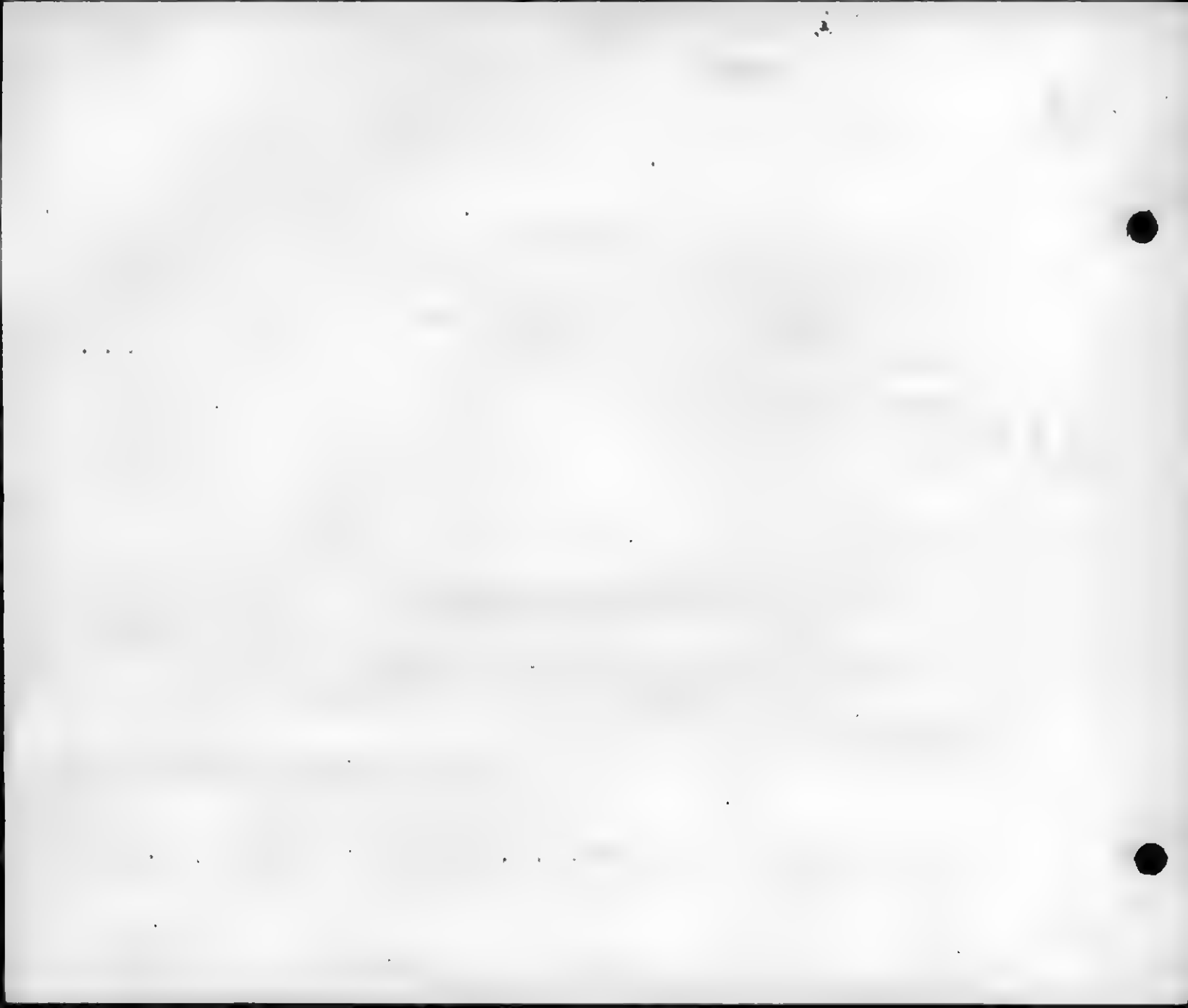
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

4187

4103

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN lb <b>2mo. 3 days</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Keedysville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		d. STREET ADDRESS <b>Rt. 1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mamie Fisher</b>		4. DATE OF DEATH Month Day Year <b>4 22 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1901-Sept. 16</b>
9. AGE (In years last birthday) <b>58</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min. <b>7 6</b>	11. IF UNDER 24 HRS Hours Min. <b>6</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown SHARPSBORO MD.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown CHARLES DEETS</b>		14. MOTHER'S MAIDEN NAME <b>Unknown ALICE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypostatic Pneumonia</b> DUE TO <b>Marked Anoxia</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>-----</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>4:10</b> p. m. 19 <b>60</b>		20d. INJURY OCCURRED at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <b>factory street office bldg. etc.</b>		20f. (City or town) (County) (State) <b>Keedysville Washington</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>2/19</b> , 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>4/22</b> , 19 <b>60</b> , and that death occurred at <b>4:10</b> p. m. from the causes and on the date stated above			
22a. SIGNATURE <b>Hildegard Heard Reissman</b> M.D.		22b. DATE SIGNED <b>4/22/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissman, M.D.</b>		22d. ADDRESS <b>Crownsville State Hospital, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>APR. 25, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>RED HILL CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>KEEDYSVILLE WASH. CO. MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John E. West</b>		25a. REC'D BY REGISTRAR <b>Boonsboro MD.</b>	
25b. REGISTRAR'S SIGNATURE <b>William S. Hanna</b>		DATE <b>APR 28 '60</b>	



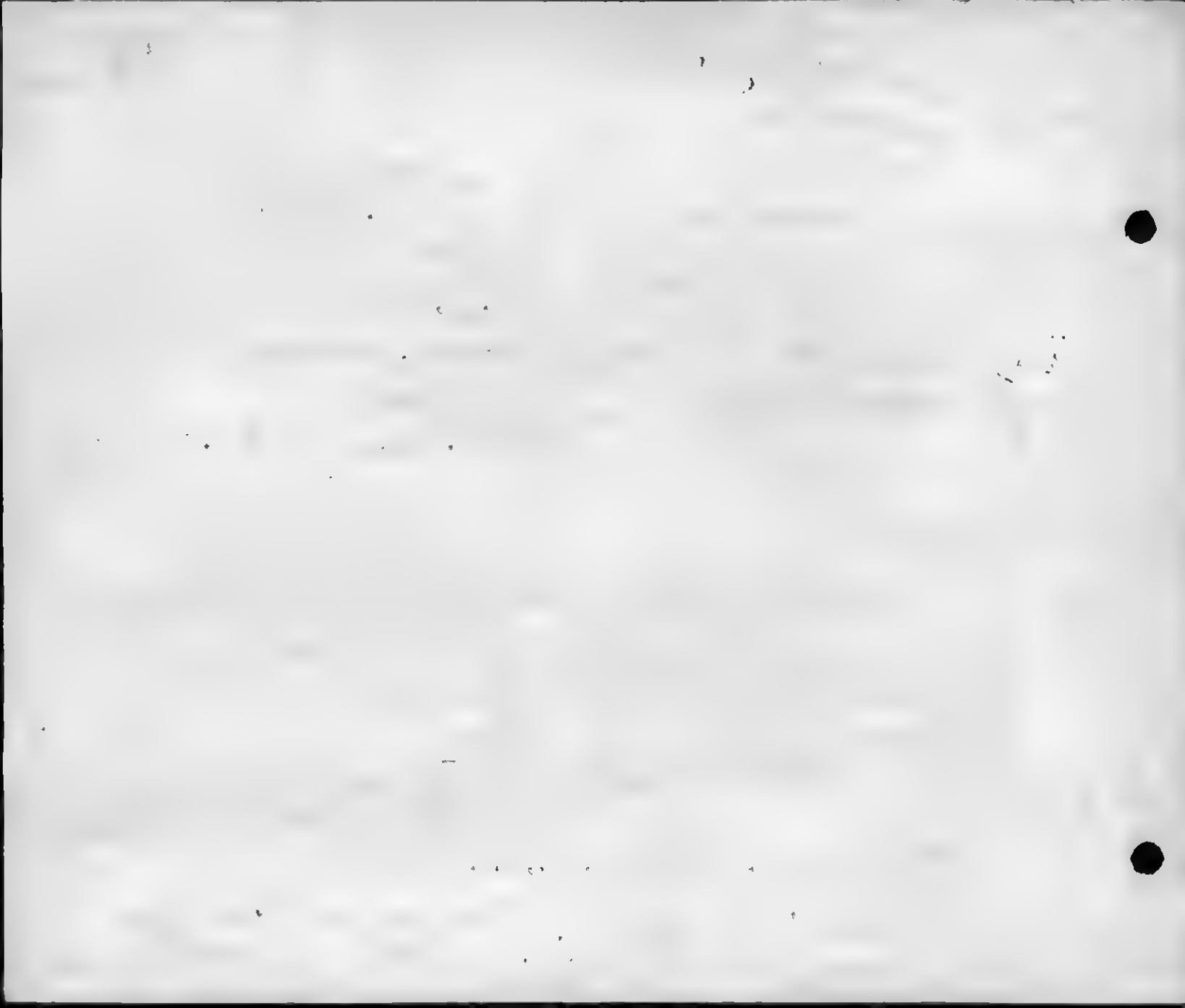


# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
<div>Items 18-21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100</div> <div>4188 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 64104</div>											
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Rose Haven</b> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Rose Haven Boat Club</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Virginia</b> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b> d. STREET ADDRESS <b>5302 N. 18th Street</b>					
3. NAME OF DECEASED (Type or print) <b>JOHN HENRY GILLIGAN</b>						4. DATE OF DEATH Month <b>April</b> Day <b>29</b> Year <b>1960</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 22, 1904</b>		9. AGE (In years last birthday) <b>55</b> yrs.		10. IF UNDER 1 YEAR Months <b>55</b> Days <b>55</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Medical Doctor</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>Medicine</b>					
11. BIRTHPLACE (State or foreign country) <b>Pittston, Pennsylvania</b>						12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <b>Thomas Joseph Gilligan</b>						14. MOTHER'S MAIDEN NAME <b>Mary Flynn</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)						16. SOCIAL SECURITY NO. 17. INFORMANT <b>Eileen B. Gilligan</b> Address <b>5302 N. 18th Street</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> 729.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>729.8</b> (c) <b>729.8</b> DUE TO cause listed.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Found floating in water</b>					
20c. TIME OF INJURY Month, Day, Year <b>4/28/60</b> Hour <b>4:28</b> p.m.						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Water</b>						20f. (City or town) <b>Anne Arundel</b> (State) <b>Md.</b>					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>W. Bradley King, Jr.</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>W. Bradley King, Jr., M.D.</b>						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED <b>4/29/60</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>						22b. DATE THEREOF <b>May 2, 1960</b>					
22c. NAME OF CEMETERY OR CREMATORY <b>Columbia Gardens</b>						22d. LOCATION (City, town, or country) <b>Arlington, Virginia</b>					
23. FUNERAL DIRECTOR <b>Ives Funeral Home, 2847 Wilson Blvd.</b>						24a. REC'D BY REGISTRAR <b>DATE MAY 4 '60</b>					
By: <b>W. Bradley King, Jr.</b> <b>Arlington, Va.</b>						24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>					



1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

64105

4189 CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN lb <b>3mo. 16 yrs. 7 days</b>		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eastport</b>		d. STREET ADDRESS <b>314 Chester Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		3 NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>Gray</b> Last <b>Gray</b>		4. DATE OF DEATH Month <b>4</b> Day <b>11</b> Year <b>1960</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 2, 1897</b>		9. AGE (In years last birthday) <b>61</b> yrs		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>11</b> Hours <b>19</b> Min. <b>60</b>			
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY -----		11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Elias Booth</b>		14. MOTHER'S MAIDEN NAME <b>Julia Bumble</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b>			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Decubital Ulcers - Old Right Hemiparesis</b> DUE TO (c) <b>Arteriosclerotic Cardiovascular Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND.TION GIVEN IN PART I (a) <b>Mendel-Bechterew, Bronchopneumonia</b>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) -----		20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from <b>1/4</b> to <b>4/11</b> , 1960, that (I) (we) last saw the deceased alive on <b>4/11</b> 19 <b>60</b> , and that death occurred at <b>4:30 P.</b> from the causes and on the date stated above.		22a. SIGNATURE <b>Hildegard Heard Reissman, M. D.</b>		22b. DATE <b>4/12/60</b>		22c. PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissman, M. D.</b>		22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>		23a. BURIAL, CREMAT ON, REMOVAL (Specify) <b>4-14-60</b>		23b. DATE THEREOF <b>4-14-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ant-rap-olis Field</b>		23d. LOCATION (City, town, or county) (State) <b>Ant-rap-olis Field, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur L. Hanna</b>		ADDRESS <b>Ant-rap-olis Field, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 13 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>		25c. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>		25d. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>		25e. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>		25f. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>		25g. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>			

422.1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4190 CERTIFICATE OF DEATH

64106  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena, RFD</b>			c. LENGTH OF STAY IN 1b <b>5 yrs.</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena, RFD (Magothy Beach)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Magothy Beach</b>				d. STREET ADDRESS <b>Rt. 5 Box 191A, Riverside Dr.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ALLEN F. HAMPSHIRE</b>				4. DATE OF DEATH Month <b>4</b> - Day <b>8</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2nd April 1898</b>	
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) <b>Hoffmansville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter (ret.)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Armco Steel Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Hoffmansville, Md.</b>	
13. FATHER'S NAME <b>(unknown) Hampshire</b>				14. MOTHER'S MAIDEN NAME <b>Clara Gibbons</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Mrs. Ethel P. Hampshire</b> Address <b>Same As #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <b>CORONARY ATHEROSCLEROSIS</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b> <b>5 YRS.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>APRIL 4-2, 1960</b> , to <b>APRIL 10, 1960</b> , that I last saw the deceased alive on <b>4-2, 1960</b> , and that death occurred at <b>10:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Glen Burnie, Maryland</b> DATE SIGNED <b>4-9-60</b>							
ACTUAL SIGNATURE <b>Leon C. Perry</b>				M.D. <b>Glen Burnie, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>Leon C. Perry</b>				M.D. <b>Glen Burnie, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12th April 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Brooklyn RFD, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. D. Sington</b>				ADDRESS <b>Glen Burnie, Maryland</b>		24a. REC'D BY REGISTRAR <b>APR 12 '60</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

420.1

may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12 11 10  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4138 CERTIFICATE OF DEATH

64107

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>10</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			
f. STREET ADDRESS <b>137 Archwood Ave.,</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Forest</b> Middle <b>B.</b> Last <b>HARDER</b>				4. DATE OF DEATH Month <b>April</b> Day <b>16</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 3, 1884</b>	
9. AGE (In years last birthday) <b>76</b> yrs		10. IF UNDER 1 YEAR Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min <b>76</b>		11. IF UNDER 24 HRS Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min <b>76</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>CITY FREMAN</b>			
11. BIRTHPLACE (State or foreign country) <b>New York</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Robert J. Harder</b>				14. MOTHER'S MAIDEN NAME <b>Minnie McCabe</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>—</b>			
17. INFORMANT <b>Forest W. Harder</b>				Address <b>(2)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO <b>420</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Thrombosis</b> DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>4 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>4/12/60</b> to <b>4/16/60</b> , that (I) (we) lost saw the deceased alive on <b>4/16/60</b> , and that death occurred at <b>1:15P</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Maurice Klawans</b>				22b. DATE SIGNED <b>4/18/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>Maurice Klawans</b>				22d. ADDRESS <b>31 Southgate Ave., Annapolis, Md.</b>			
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Apr 19-1960</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Regina Blue Cent</b>				23d. LOCATION (City, town, or county) (State) <b>Annapolis Md</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor</b>				25a. REC'D BY REGISTRAR <b>APR 20 '60</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>							





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4139

## CERTIFICATE OF DEATH

Reg. Dist. No.

04108

1. PLACE OF DEATH a. COUNTY <u>aa</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>18</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8 Clifton Place</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>aa</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md</u> d. STREET ADDRESS <u>8 Clifton Place</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CAROLYN Lee</u> Middle <u>Healy</u> Last		4. DATE OF DEATH Month <u>4</u> - Day <u>4</u> - Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 3 1889</u> 9. AGE (In years last birthday) <u>72</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Darlingtonville Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Richard M. Waters</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Lee</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs Raymond J. Connell</u> Address <u>2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of lungs</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cancer of left Breast</u> (c) <u>Coronary Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Several mos.</u> <u>Several yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10 - 26 1959</u> to <u>4 - 4 - 1960</u> , that I last saw the deceased alive on <u>4 - 3 - 1960</u> , and that death occurred at <u>5:25 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Oliver Purvis</u>		ADDRESS (Street, city or town, state) <u>40 Franklin St Annapolis Md</u> DATE SIGNED <u>4/5/60</u>	
PHYSICIAN'S NAME (Type) <u>J. Oliver Purvis</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-6-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cent</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor Sins</u> ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 8 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4140

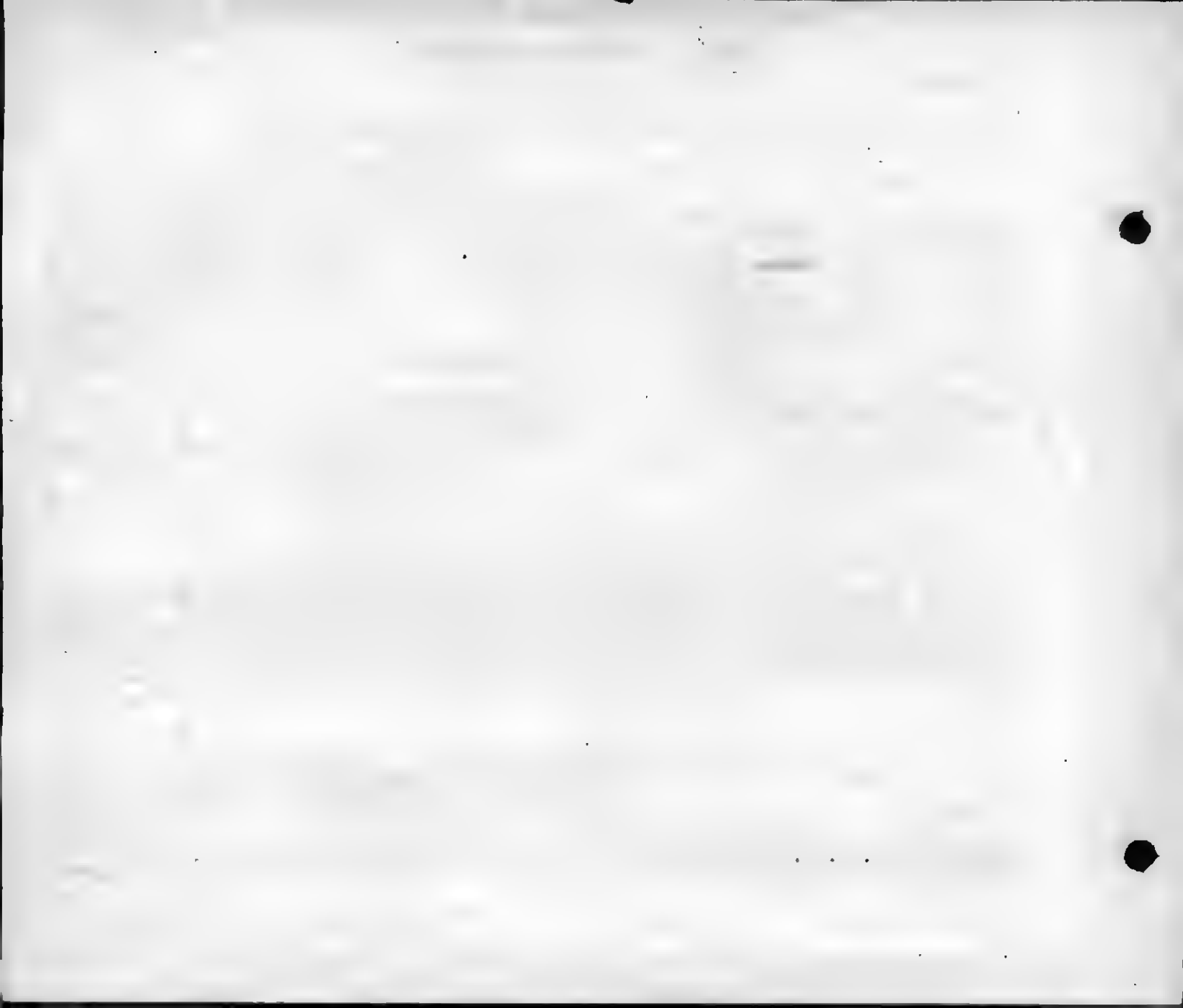
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE [Where deceased lived, If institution: Residence before admission] a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. STREET ADDRESS <b>46 Lafayette Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Holt Benjamin S.</b>		4. DATE OF DEATH Month <b>4</b> Day <b>23</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-5-74</b>
9. AGE (In years lost birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Barber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>Louis Wesley Holt</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Holt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>46-464646-464646</b>	
17. INFORMANT <b>Edna Holt</b>		Address <b>46 Lafayette Avenue Annapolis MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b> DUE TO <b>Hypertension due to chronic disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO <b>Vasculi disease</b> (c) <b>Diabetes Mellitus</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/23</b> , 19 <b>60</b> to <b>4/23</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>4/23</b> , 19 <b>60</b> , and that death occurred at <b>11:55</b> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>110 Clay Street, Annapolis, Maryland</b> DATE SIGNED <b>4/23/60</b>			
ACTUAL SIGNATURE <b>R. L. Richardson</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Dr. R. L. Richardson</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>4-27-60</b>	<b>Brewer Hill</b>	<b>Annapolis MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese #108</b>		24. REC'D BY REGISTRAR DATE <b>MAY 3 60</b>	
ADDRESS <b>108 West St. Annapolis</b>		25. REGISTRAR'S SIGNATURE <b>Charles S. Hanna</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
MAYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4191 CERTIFICATE OF DEATH 04110

1 PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>3yrs. 7mos. 29 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>41 N. Gorman Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Lottie</b> Middle <b>Jackson</b> Last 5. SEX <b>Female</b> 6. COLOR OR RACE <b>Negro</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>7/15/1878</b> 9. AGE (In years lost birthday) <b>81</b> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.		4. DATE OF DEATH Month <b>4</b> Day <b>13</b> Year <b>19 60</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>-----</b> 11. BIRTHPLACE (State or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John W. Matthews</b>		14. MOTHER'S MAIDEN NAME <b>Sarah</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>unknown</b> 17. INFORMANT <b>Medical Records</b> Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>443X</b> IMMEDIATE CAUSE (a) <b>Uremia</b> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Hypertensive Cardiovascular Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome Associated with Senile Arteriosclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year <b>8/14 19 56</b> <b>Home</b> <input checked="" type="checkbox"/> <b>Work</b> <input type="checkbox"/> <b>While at work</b> <input type="checkbox"/> <b>Not while at work</b> <input type="checkbox"/>		20d. INJURY OCCURRED <b>While at work</b> <input type="checkbox"/> <b>Not while at work</b> <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>4/13</b> 20f. (City or town) <b>4/13</b> (County) <b>19 60</b> (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>8/14 19 56</b> that (I) (we) last saw the deceased alive on <b>4/13 19 60</b> , and that death occurred at <b>10:45 P. M.</b> from the causes and on the date stated above			
22a. SIGNATURE <b>Hildegard Heard Reissmann</b> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 4-14-60		22b. DATE SIGNED <b>4-14-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissmann, M. D.</b>		22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>4-18-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>WESTERN STAR CEM</b>	23d. LOCATION (City town or county) (State) <b>CATONSVILLE, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Isaiah R. Brown &amp; Son</b> ADDRESS <b>108 W. Montgomery</b>		25a. REC'D BY REGISTRAR <b>APR 14 1960</b> 25b. REGISTRAR'S SIGNATURE <b>Isaiah R. Brown</b>	

4/11/21

may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4141 CERTIFICATE OF DEATH

04111

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>RURAL - Annapolis</b>			
c. LENGTH OF STAY IN 1b <b>2 days</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>Rt-2, Box-382</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Barry L. Johnson</b>		First Middle Last <b>JOHNSON</b>		4. DATE OF DEATH Month <b>April</b> Day <b>4</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 2, 1960</b>		9. AGE (In years last birthday) yrs <b>1</b> Months <b>1</b> Days <b>23</b> Hours <b>23</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William Mack Kaham</b>				14. MOTHER'S MAIDEN NAME <b>Helen Marie Johnson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Abortion</b> <b>762.5</b> DUE TO <b>Pregnancy</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 2, 1960</b> , to <b>April 4, 1960</b> , that (I) (we) last saw the deceased alive on <b>April 4, 1960</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Philip Briscoe</b>				22b. DATE <b>1:35P.</b>		22c. PHYSICIAN'S NAME (Type) <b>Philip Briscoe</b>	
22d. ADDRESS <b>95 Cathedral St., Annapolis, Md.</b>				22e. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-9-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Broadneck</b>		23d. LOCATION (City, town, or county) (State) <b>St. Margaret M.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>William Kessett</b>				25a. REC'D BY REGISTRAR DATE <b>APR 13 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

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may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
4142  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04112

1 PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>1019 Smithville St.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>JOHNSON</b> Last <b>JOHNSON</b>				4. DATE OF DEATH Month <b>April</b> Day <b>7</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 12, 1896</b>	
9 AGE (In years last birthday) <b>64</b> yrs		IF UNDER 1 YEAR Months <b>64</b> Days <b>64</b> Hours <b>64</b> Min <b>64</b>		IF UNDER 24 HRS Months <b>64</b> Days <b>64</b> Hours <b>64</b> Min <b>64</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13 FATHER'S NAME <b>George Andrew Savoy</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Catoll</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16 SOCIAL SECURITY NO.		17. INFORMANT <b>Chas Johnson 1019 Smithville St Anne</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia, chronic Severe</b> <b>197.2</b> DUE TO <b>Generalized Carcinomatous</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Carcinomatous</b> DUE TO (c) <b>Generalized Carcinomatous</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o m. <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>Sept. 12, 55</b> to <b>Apr. 7, 1960</b> , that (I) (we) last saw the deceased alive on <b>Apr. 7, 1960</b> , and that death occurred at <b>6:15P.</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>A. T. Allen</b>				22b. DATE <b>4/8/60</b>		22c. PHYSICIAN'S NAME (Type) <b>A. T. Allen</b>	
22d. ADDRESS <b>62 Cathedral St., Annapolis, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>4-10-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Brewer Hill</b>		23d. LOCATION (City, town, or county) (State) <b>Annapolis Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese</b>				25a. REC'D BY REGISTRAR <b>APR 13 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

199.2

may be filled in by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4192 Item 14 Film 8262 5/16/60 iwr

**CERTIFICATE OF DEATH**

64113

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>24 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		d. STREET ADDRESS <b>unknown</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CLARENCE</b>		First <b>JOHNSON</b>		Middle <b>JOHNSON</b>		Last <b>JOHNSON</b>		4. DATE OF DEATH Month <b>4</b> Day <b>8</b> Year <b>19 60</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1915</b>		9. AGE (n years last birthday) <b>45</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>8</b> Hours <b>19</b> Min. <b>60</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>					
13. FATHER'S NAME <b>Clarence Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Mary unknown</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>MEDICAL RECORDS</b>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> DUE TO <b>Hypertensive Cardio-Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>---</b>									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>---</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>---</b>		20f. (City or town) <b>---</b>		(County) <b>---</b>		(State) <b>---</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>3/15/60</b> , 19 <b>60</b> , to <b>4/8/</b> , 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>4/8/</b> , 19 <b>60</b> , and that death occurred at <b>1:45 P.M.</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Hildegard Heard Reissmann</b>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. ADDRESS <b>Crownsville State Hospital, 4/8/60</b>						22c. DATE SIGNED <b>4/8/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>4-12-60</b>		23b. DATE THEREOF <b>4-12-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>---</b>		23d. LOCATION (City, town, or county) <b>---</b>		(State) <b>---</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis A. Heinsky</b>		ADDRESS <b>576 W. 8th St.</b>		25a. RECORD BY REGISTRAR <b>APR 12 60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kinn</b>					

424

## Reg. Dist. No.

## MEDICAL CERTIFICATION

VS A75 (4)  
15M 10/57

1810

4143

## CERTIFICATE OF DEATH

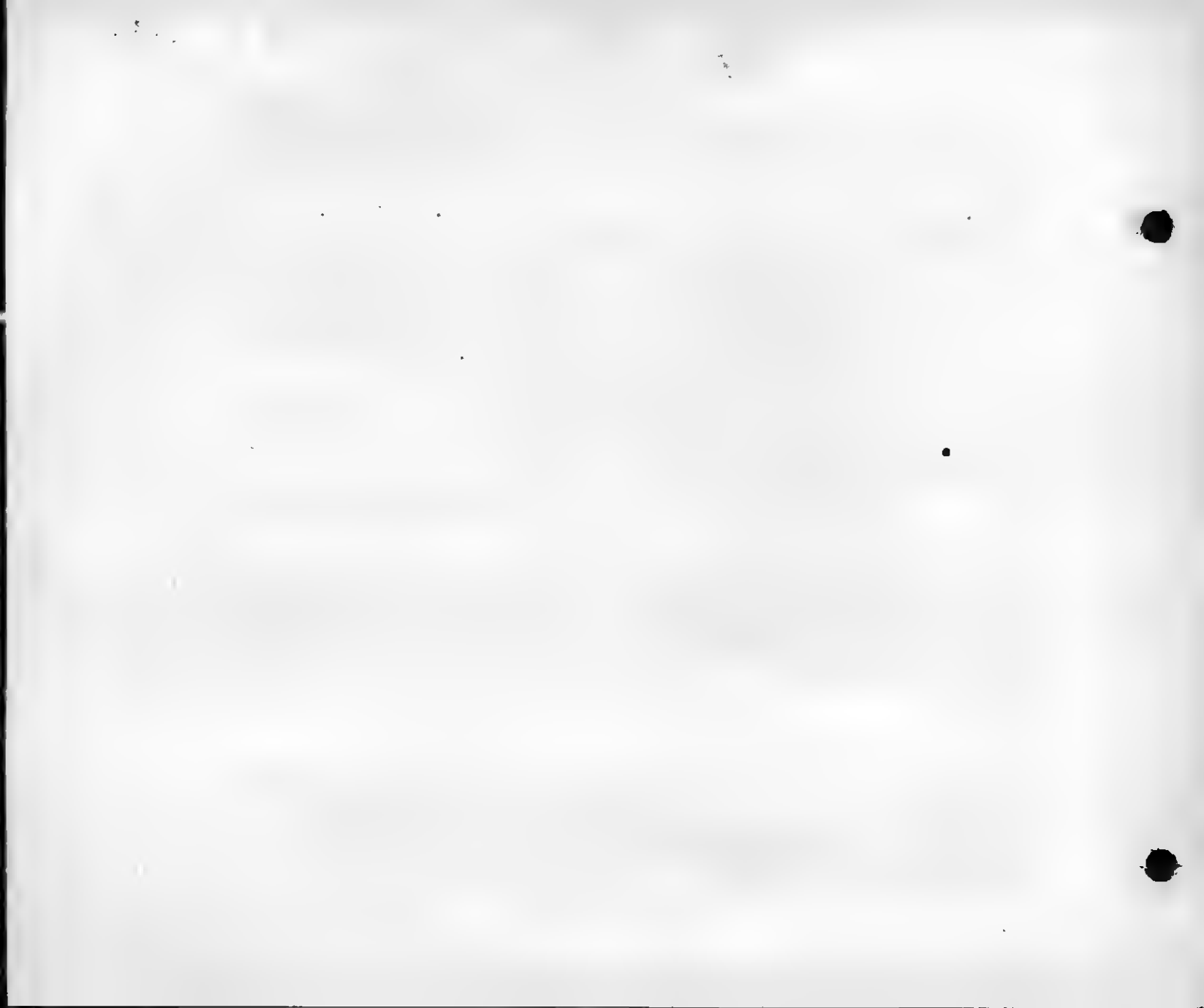
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>30 N. Glen Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY E JONES</u>				4. DATE OF DEATH Month Day Year <u>APRIL 5 1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 3, 1874</u>		9. AGE (In years lost birthday) yrs. <u>85</u>	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE WILL</u>				14. MOTHER'S MAIDEN NAME <u>Mary Earheart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs Sewell Sweeney- Daughter- same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cute myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic atherosclerotic cardiovascular disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u> <u>5 pm.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 195 <u>5</u> , to <u>April</u> , 196 <u>0</u> , that I last saw the deceased alive on <u>4/7/60</u> , 196 <u>0</u> , and that death occurred at <u>6:40</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>121 Cathedral Street, Annapolis, Maryland</u> DATE SIGNED <u>4/7/60</u>							
ACTUAL SIGNATURE <u>John H. Hedeman</u> M.D.				PHYSICIAN'S NAME (Type) <u>Frank Stingley MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 7, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Remington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Remington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>				ADDRESS <u>Annapolis, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>APR 11 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Curtis E. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





4144

## CERTIFICATE OF DEATH

64116

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HUNNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>A.A.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HUNNE ARUNDEL</u>		c. LENGTH OF STAY IN 1b <u>X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>H.A. GENERAL Hospital</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>OLGA</u> <u>KISSER</u>		4. DATE OF DEATH Month Day Year <u>4</u> <u>11</u> <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-19-1894</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>N. DAKOTA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>GUSTAVE HARMEL</u>		14. MOTHER'S MAIDEN NAME <u>JULIA LENIZ</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>RICHARD KISSER</u> Address <u># 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Acute pulmonary Edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Arteriosclerosis</u> DUE TO <u>Coronary Arteriosclerosis</u> (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u> <u>YRS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/11/60</u> , 19 <u>60</u> , to <u>4/11/60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/11</u> , 19 <u>60</u> , and that death occurred at <u>8:40 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard N. Peeler</u> M.D.		ADDRESS (Street, city or town, state) <u>121 CATHEDRAL ST</u> DATE SIGNED <u>4/11/60</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD N. PEELER</u>		<u>ANNAPOLIS, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-14-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT. OAK</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGES MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor &amp; Son</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>APR 14 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4 20.0

4194

## CERTIFICATE OF DEATH

04117

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Ferndale Ave., Ferndale</i>		d. STREET ADDRESS <i>Ferndale Ave., Ferndale</i>	
3. NAME OF DECEASED (Type or print) <i>HATTIE KLEIN</i>		4. DATE OF DEATH Month <i>4</i> Day <i>13</i> Year <i>1960</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-22-1897</i>
9. AGE (In years last birthday) <i>62</i> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Assembly Work</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Calvert Distillery</i>	
11. BIRTHPLACE (State or foreign country) <i>Balto., Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Leineweber</i>		14. MOTHER'S MAIDEN NAME <i>Katherine Butzel</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-01-6135</i>	
17. INFORMANT <i>Mr. Elmer L. Klein</i>		Address <i>Same As Above</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic heart disease</i> DUE TO (c) <i>Arteriosclerosis general</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>diabetes mellitus</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Mar</i> , 1960, to <i>April 13</i> , 1960, that I last saw the deceased alive on <i>April 11</i> , 1960, and that death occurred at <i>—</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Joseph Taler</i> , M.D.		ADDRESS (Street, city or town, state) <i>102 Bx A Blvd. N.E.</i>	
PHYSICIAN'S NAME (Type) <i>JOSEPH TALER, M.D.</i>		DATE SIGNED <i>Glen Burnie, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>16 Apr - 1960</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. S. Singleton</i>		24a. REC'D BY REGISTRAR <i>APR 18 '60</i>	
ADDRESS <i>Glen Burnie, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. [illegible]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



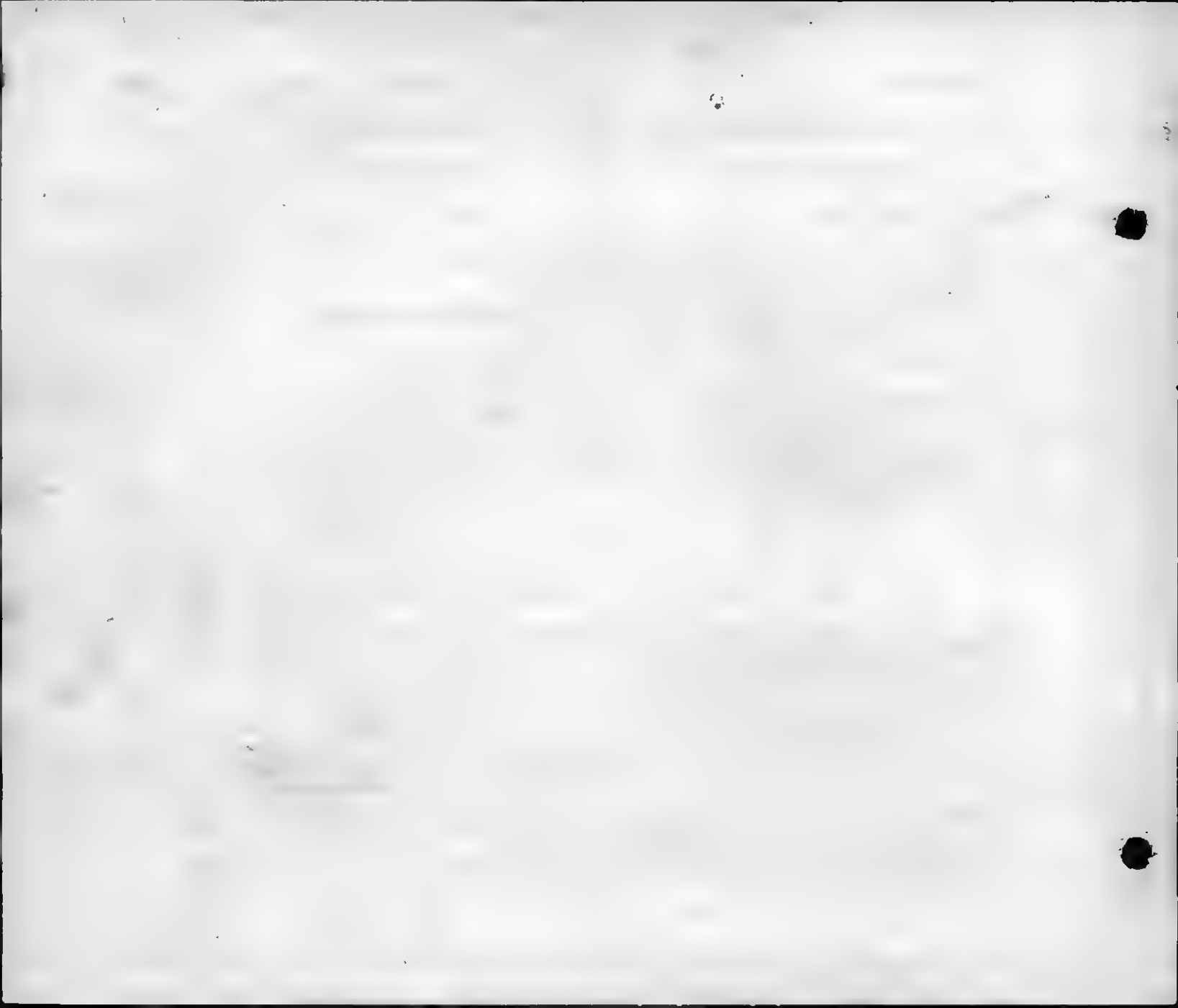
## 4195 CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>A.A. Co MD.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. LENGTH OF STAY IN 1b <u>1 week</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CHELSEA BEACH</u>		d. STREET ADDRESS <u>130 S. WASHINGTON ST</u>	
3 NAME OF DECEASED (Type or print) <u>JOSEPH</u> First <u>KORDECKI</u> Middle <u>HELEN-TURC</u> Last		4. DATE OF DEATH <u>April 9</u> Month <u>9</u> Day <u>1960</u> Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 19-1891</u>
9. AGE (In years lost birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Longshoreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ships</u>	
11. BIRTHPLACE (State or foreign country) <u>POLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Kordecki</u>		14. MOTHER'S MAIDEN NAME <u>Zysk</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>215-05-3283</u>	
17. INFORMANT <u>HELEN-TURC</u> Address <u>Chelsea Beach A.A. Co</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the lung</u> <u>165X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1 year</u> DUE TO (c) <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 31, 1960</u> to <u>April 9, 1960</u> , that I last saw the deceased alive on <u>April 7, 1960</u> , and that death occurred at <u>1:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R.M. McLaughlin</u> M.D.		ADDRESS (Street, city or town, state) <u>308 Mountain Road Pasadena Md</u> DATE SIGNED <u>April 9, 1960</u>	
PHYSICIAN'S NAME (Type) <u>R.M. McLaughlin</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/12/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart of Mary</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Co MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. S. Fialkowski</u> ADDRESS <u>2007 Eastern Ave</u>		24a. REC'D BY REGISTRAR <u>APR 11 '60</u> DATE 24b. REGISTRAR'S SIGNATURE <u>Guthrie L. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie Md</u>				c. LENGTH OF STAY IN 1b <u>5 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>101 Martin Rd.</u>				e. STREET ADDRESS <u>2705 Chalkland St</u>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Pacoli</u> Last <u>Krauser</u>				4. DATE OF DEATH Month <u>April</u> Day <u>27</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 2, 1914</u>	
9. AGE (In years last birthday) <u>45</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Venezuela</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Pacoli</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>84111</u>		17. INFORMANT <u>MARY ANN BROWN</u> Address <u>101 Martin Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Spontaneous Failure</u>						3 min.	
DUE TO <u>Pulmonary Edema</u>						2 days	
DUE TO <u>Bronchogenic Carcinoma</u>						1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Smoking</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. — p.m. — 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 5, 1960</u> to <u>April 27, 1960</u> , that I last saw the deceased alive on <u>April 26, 1960</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. W. FRIEDMAN</u> M.D.				DATE SIGNED <u>April 27, 1960</u>			
PHYSICIAN'S NAME (Type) <u>R. W. FRIEDMAN</u>				<u>Glen Burnie Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 28, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Pk.</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jeffrey Kelly, Jr.</u> ADDRESS <u>Home, 101 Martin Rd.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



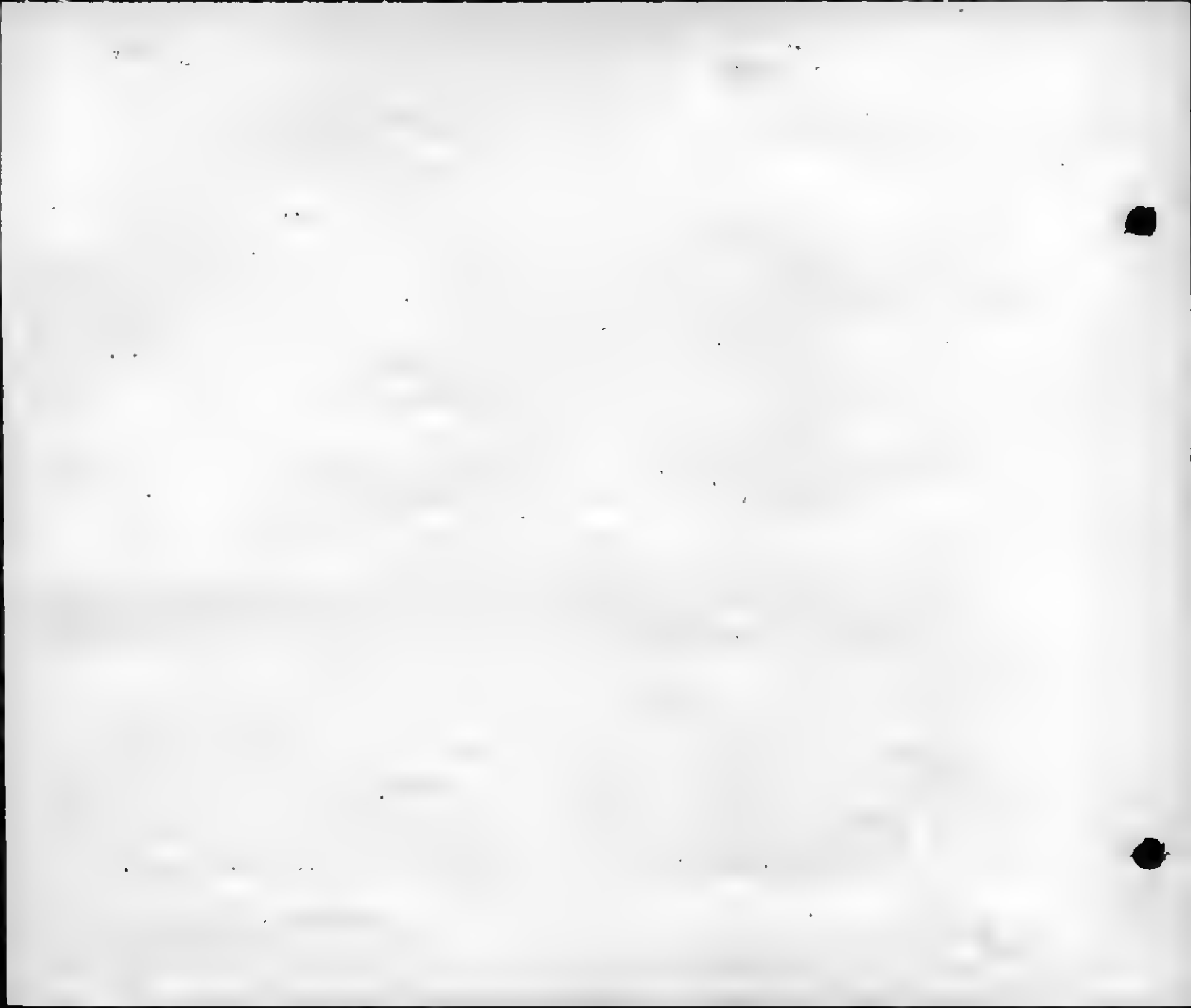


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4145  
CERTIFICATE OF DEATH

64120

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital (DOA)</b>				d. STREET ADDRESS <b>30 Murray Ave.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF (Type or print) <b>Morris</b>		First Middle Last <b>LEGUM</b>		4. DATE OF DEATH <b>April 18 1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1876</b>		9. AGE (In years last birthday) <b>84 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real Estate Investor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Rental of Own Properties</b>		11. BIRTHPLACE (State or foreign country) <b>Lithuania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Julius Legum</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Hospital records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Acute coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO <b>192</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cholesterol build-up</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Baltimore</b>				20g. (County) <b>Baltimore</b>		20h. (State) <b>Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>6/20</b> 19 <b>59</b> to <b>4/18</b> 19 <b>60</b> that (I) (we) last saw the deceased alive on <b>2/2</b> 19 <b>60</b> , and that death occurred at <b>7:55A.</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Richard N. Peeler</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/18/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Richard N. Peeler</b>				22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr, 20, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mikro Kodesh Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>				ADDRESS <b>Annapolis, Maryland</b>		25a. REC'D BY REGISTRAR <b>DATE APR 22 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles L. Hume</b>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1864121									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No.									
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>4th</u>				
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Annapolis</u>					c. LENGTH OF STAY IN 1b <u>1 day</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS <u>1411-9 St SE</u>				
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Everett</u> Last <u>Mason</u>					4. DATE OF DEATH Month <u>Apr</u> Day <u>17</u> Year <u>1960</u>				
5. SEX <u>M</u>		6. COLOR OR RACE <u>BL</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 26, 1923</u>		9. AGE (in years last birthday) <u>36</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
<u>Baggage porter</u>		<u>Mar. Terminal</u>		<u>St Marys Co. Md</u>			<u>USA</u>		
13. FATHER'S NAME <u>James C. Mason</u>					14. MOTHER'S MAIDEN NAME <u>Beatrice R. Jones</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW II</u>					16. SOCIAL SECURITY NO. <u>216-12-4379</u>				
17. INFORMANT <u>Mrs. Mary Mason</u>					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental drowning</u> <u>850X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____ YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Fell overboard from boat while boating</u>				
20c. TIME OF INJURY Month, Day, Year <u>2:30</u> <u>4/17/</u> <u>1960</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Back Creek</u>					20f. (City or town) (County) (State) <u>Annapolis</u> <u>MD</u>				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>S. Boersuck</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>S. Boersuck</u>					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> acting				
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <u>4/17/60</u>				
22a. BURIAL CREMATION OR REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>April 22-1960</u>				
22c. NAME OF CEMETERY OR CREMATORY <u>Urbington National</u>					22d. LOCATION (City, town, or county) (State) <u>Fort Meyer</u> <u>VA</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hazen Funeral Home</u>					24a. REC'D BY REGISTRAR <u>389-RD Ave. S.W. DC</u>				
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiana</u>					DATE <u>APR 20 '60</u>				



4197

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mountain Road</b>		d. STREET ADDRESS <b>Rt. 7 Box 327 Mountain Road</b>	
3. NAME OF DECEASED (Type or print) First <b>PIERCE T.</b> Middle <b>MEAGHER</b> Last		4. DATE OF DEATH Month <b>April</b> Day <b>30</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 3, 1874</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Butcher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Meat</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Philip T. Meagher</b>		14. MOTHER'S MAIDEN NAME <b>Sarah E. Potter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-07-0791</b>	
17. INFORMANT <b>Mrs. Jane C. Meagher</b>		Address <b>Same</b>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Decompenstation</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b> <b>2 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 15, 1959</b> to <b>April 30, 1960</b> , that I last saw the deceased alive on <b>April 28, 1960</b> , and that death occurred at <b>5:00 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>R. M. McLaughlin</b>		ADDRESS (Street, city or town, state) <b>3108 Mountain Rd. Pasadena, Md.</b>	
PHYSICIAN'S NAME (Type) <b>R. M. McLaughlin</b>		DATE SIGNED <b>Apr 30, 1960</b>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 3, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Taylor Ave. Balto. Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>George J. Bond</b>		ADDRESS <b>4001 Ritchie Hwy. (25)</b>	24a. REC'D BY REGISTRAR <b>MAY 5 '60</b>
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneass</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

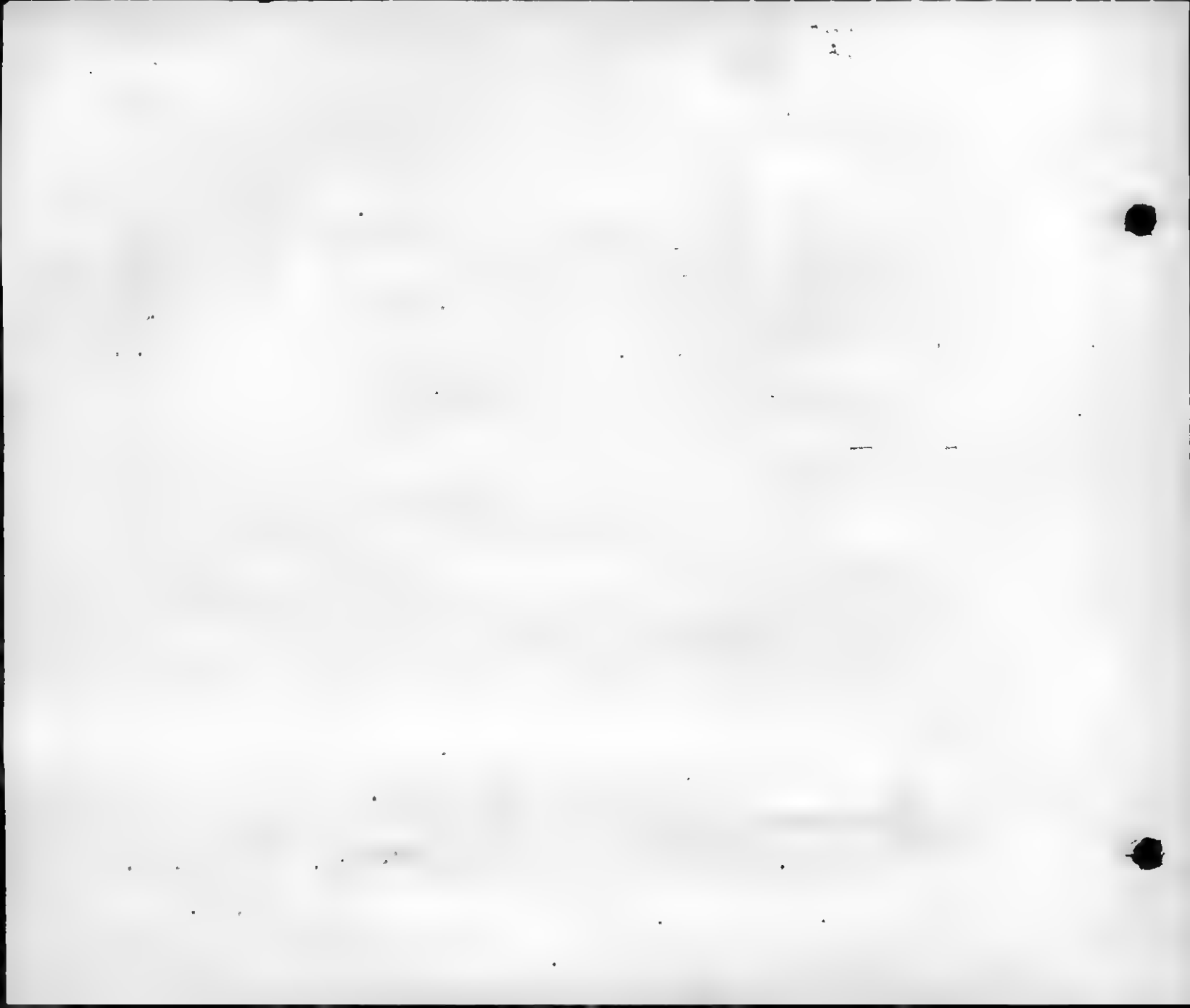


**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**4147** **CERTIFICATE OF DEATH**

04124

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				e. STREET ADDRESS <b>328 First St.</b>			
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>G</b> Last <b>MIDDLETON</b>				4. DATE OF DEATH Month <b>April</b> Day <b>19</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 20, 1886</b>		9. AGE (In years last birthday) <b>73</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired- Watchman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Ralph Middleton</b>				14. MOTHER'S MAIDEN NAME <b>Katherine Burns</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>none</b>				16. SOCIAL SECURITY NO. <b>none</b>			
17. INFORMANT <b>Hospital Records,</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EMBOLISM</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROSIS, GENERALIZED</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>24 HOURS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ACUTE MONOBLASTIC LEUKEMIA</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 4, 1960</b> to <b>April 18, 1960</b> , that (I) (we) last saw the deceased alive on <b>April 18, 1960</b> , and that death occurred at <b>4:55 A.</b> M., from the causes and on the date stated above.							
22a. SIGNATURE <b>Edward S. Beck</b>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>4/19/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edward S. Beck</b>				22d. ADDRESS <b>11 Franklin St. 11 Southgate Ave., Annapolis, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 22, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Annapolis, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>				ADDRESS <b>Annapolis, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 22 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the registrar prior to burial, cremation, or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4148

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64125

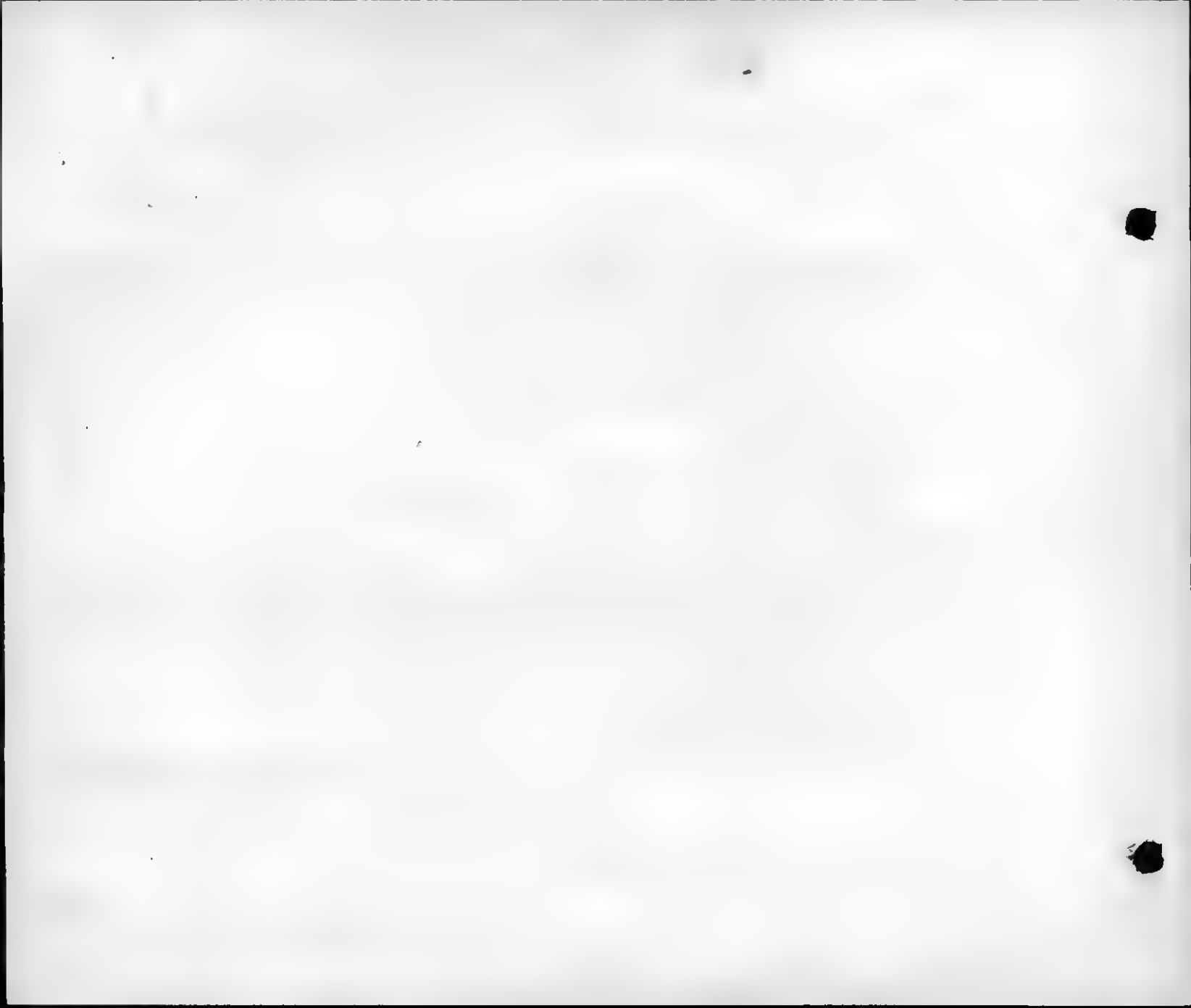
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>117 Smith Ave.</u>		d. STREET ADDRESS <u>117 Smith Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>FLORENCE FISHER MORGAN</u>		4. DATE OF DEATH <u>Apr. 6</u> 19 <u>60</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-13-1900</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>ANNAPOLIS MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LOUIS A. FISHER</u>		14. MOTHER'S MAIDEN NAME <u>MARY E. PARKINSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>RAYMOND C. MORGAN</u>		Address <u>  </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. IN [Signature]</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>APR 7/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4-11-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>	22d. LOCATION (City, town, or county) <u>ANNAPOLIS MD.</u> (State) <u>  </u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR</u> ADDRESS <u>SOV. ANNAPOLIS MD</u>		24a. REC'D BY REGISTRAR <u>  </u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

4344

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64126  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4198 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Annie Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Arundel road</u>				e. STREET ADDRESS <u>Joyce Lane</u>			
3. NAME OF DECEASED (Type or print) <u>Walter Chase Munro</u>				4. DATE OF DEATH <u>4-5-60</u> 19 <u>60</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5 Aug. 1887</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Civil Engineer</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>James M. Munro</u>				14. MOTHER'S MAIDEN NAME <u>Mary Chase</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>yes</u>				16. SOCIAL SECURITY NO. <u>Waverly W. W. I</u>			
17. INFORMANT <u>Wife</u> <u>Dyda Joyce Munroe</u> (2)				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary infarction (marked)</u> DUE TO <u>Generalized arteriosclerosis</u> (c) <u>Generalized arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> to <u>1960</u> , that (I) (we) last saw the deceased alive on <u>4-4-60</u> , and that death occurred at <u>3:45 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert R. Hahn</u> M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>				22d. ADDRESS <u>Seaside Park Rd.</u>			
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Apr. 8-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cent</u>		23d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u> ADDRESS <u>Annapolis Md</u>				25a. REC'D BY REGISTRAR <u>APR 8 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	



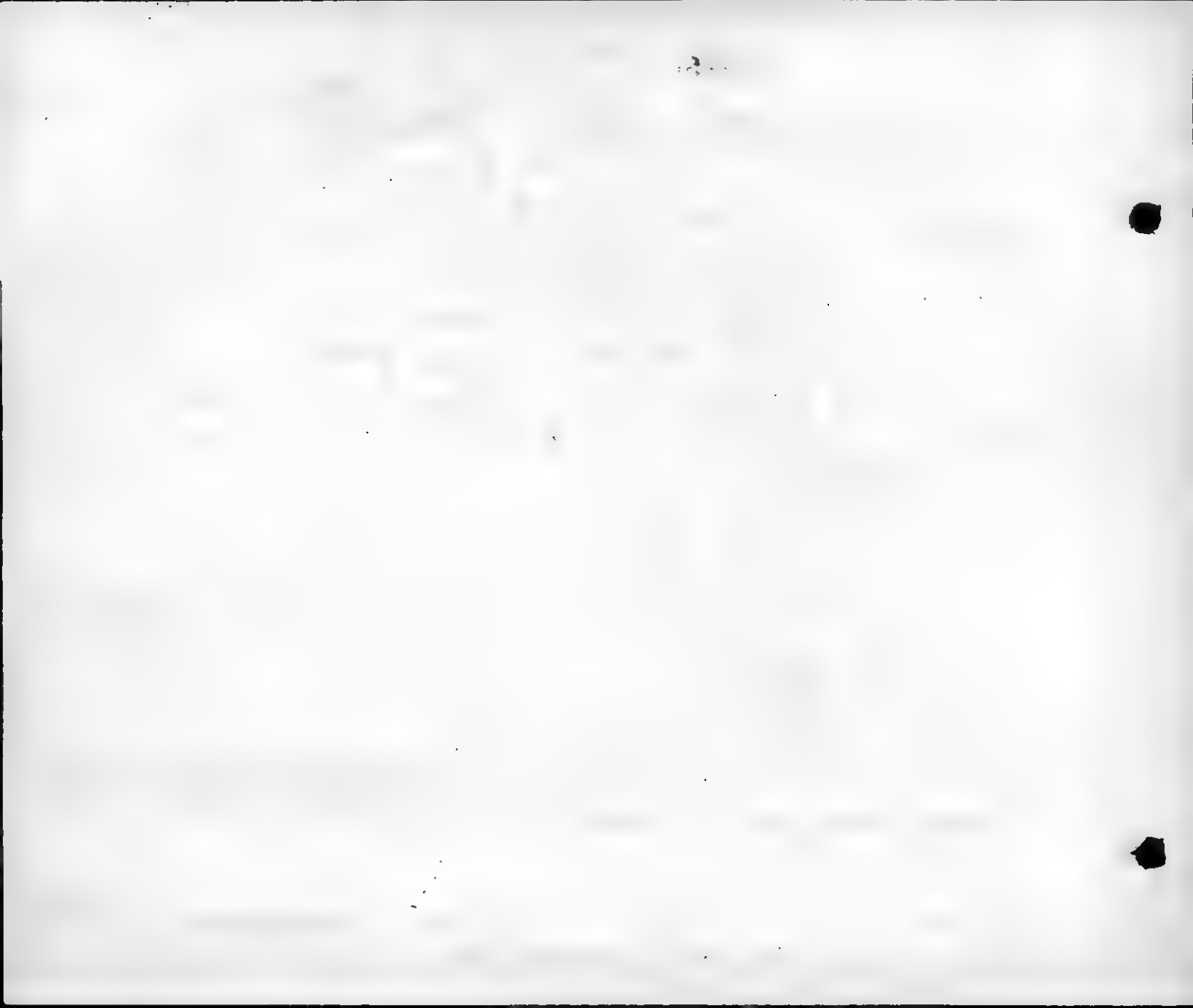
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04127

CERTIFICATE OF DEATH

Reg. Dist. No.

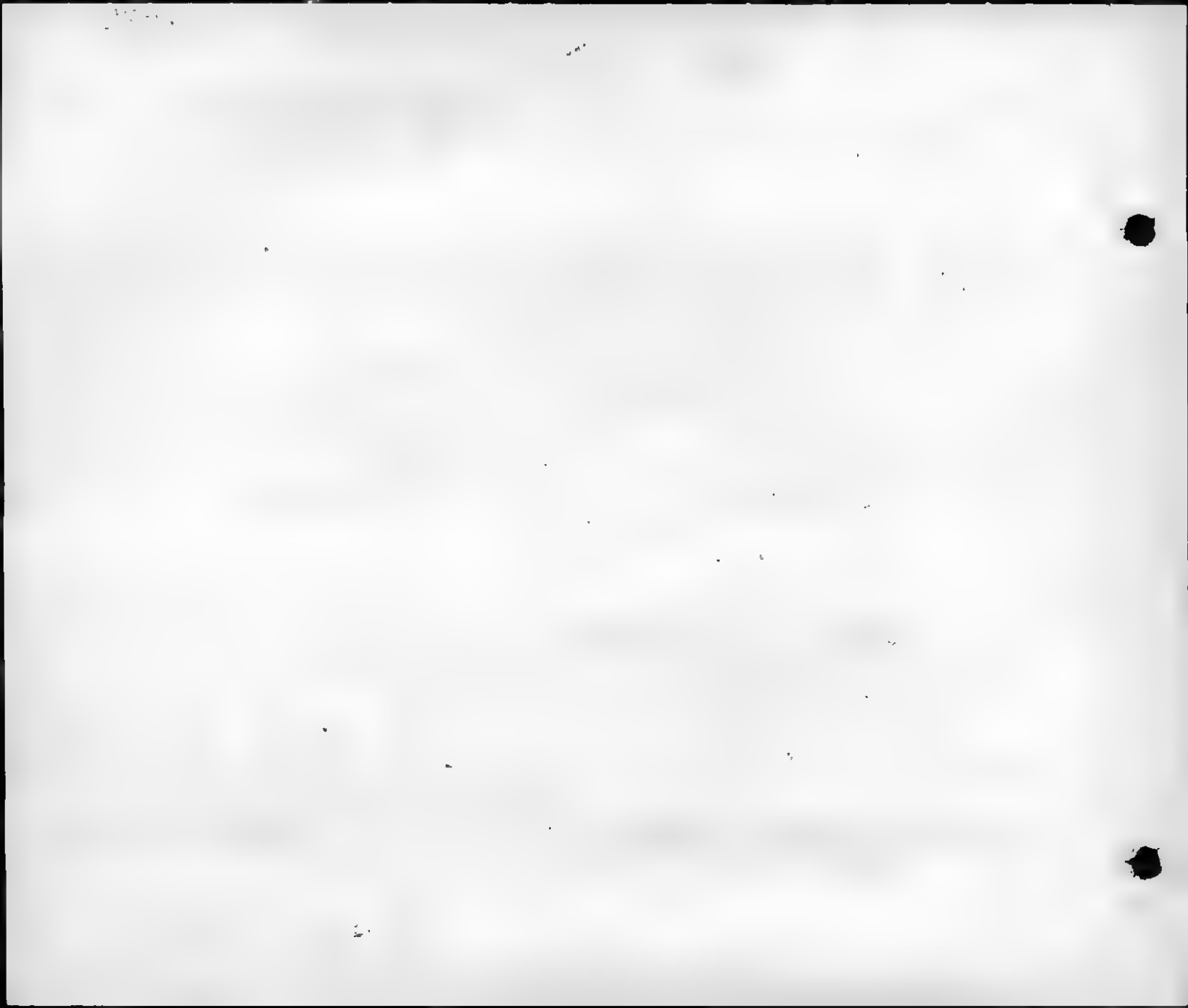
1 PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>ANNE ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits, write Rural and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write Rural and give nearest town) <b>10 Annapolis</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1 Housley Road</b>		e. STREET ADDRESS <b>1 Housley Road</b>	
3 NAME OF DECEASED (Type or print) First <b>AGNES</b> Middle <b>Mosley</b> Last <b>MUNTZ</b>		DATE OF DEATH Month <b>April</b> Day <b>24</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 6, 1878</b>
9. AGE (In years lost birthday) yrs. <b>81</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>DELAWARE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>JAMES CARNEY</b>		14. MOTHER'S MAIDEN NAME <b>HARRIETT DURHAM</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Miss Icky Mosley</b>		Address <b>#2</b>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> DUE TO (c) <b>GENERALIZED ARTERIOSCLEROSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1957</b> to <b>April</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>April 23</b> , 19 <b>60</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above			
ACTUAL SIGNATURE <b>Francis J. Gadd</b> M.D.		ADDRESS (Street, city or town, state) <b>P.O. Box 289</b>	
PHYSICIAN'S NAME (Type) <b>1</b>		DATE SIGNED <b>4-24-60</b>	
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 28-1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hellcrest Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor</b>		24a. REC'D BY REGISTRAR DATE <b>APR 28 '60</b>	
ADDRESS <b>Severna Park Md</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanes</b>	



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## 64128

1. PLACE OF DEATH a. COUNTY <u>Charles</u>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>W. &amp; A. A. C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XTC127-12000 Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sands Nursing Home</u>		d. STREET ADDRESS <u>14500 13th</u>	
3. NAME OF DECEASED (Type or print) <u>Charles S. Nicholson</u>		4. DATE OF DEATH Month <u>4</u> / Day <u>27</u> / Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-22-25</u>
9. AGE (In years last birthday) <u>41</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Fernando S. Nicholson</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth S. Nicholson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>1-30-60</u>	
17. INFORMANT <u>Family</u>		Address <u>14500 13th</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>334</u> DUE TO <u>Acute Lobar Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
(b) DUE TO <u>Septicemia</u>		<u>2 yrs</u>	
(c) DUE TO <u>Cerebral Infarct + Hemiplegia</u>		<u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Smoking</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>MD</u>
21. I certify that (I) (this hospital) attended the deceased from <u>3/14</u> to <u>4/24</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/26</u> , and that death occurred at <u>2:45</u> PM, from the causes and on the date stated above			
22a. SIGNATURE <u>JOSEPH LIPSKEY</u>		22b. DATE SIGNED <u>4/27/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH LIPSKEY</u>		22d. ADDRESS <u>Odenton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-30-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>	23d. LOCATION (City, town, or county) (State) <u>MD</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>K. L. L. 130 E. Towler</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 2 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

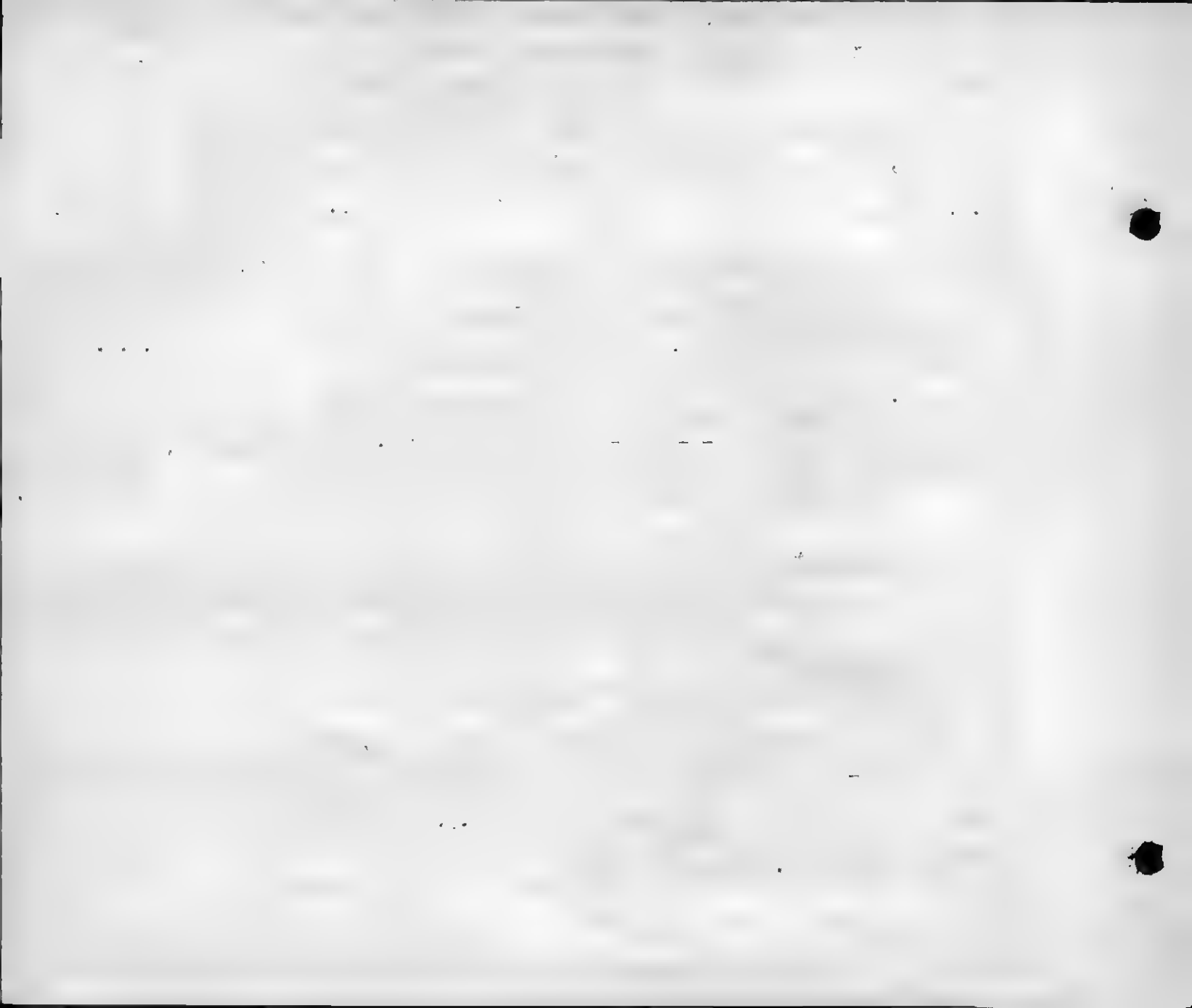
64129

## 4150 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS, MARYLAND</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>		
c. LENGTH OF STAY IN 1b <b>3hrs 52minutes</b>			d. STREET ADDRESS <b>230 SYCOMORE CT.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. NAVAL HOSPITAL</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>ALLEN WAYNE PARKS</b>			4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>1960</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>17 APRIL 1960</b>		9. AGE (In years, last birthday) yrs. <b>3</b> Months <b>52</b> Days <b>3</b> Min. <b>52</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Walter W. PARKS</b>		
14. MOTHER'S MAIDEN NAME <b>Attie Rena PELOQUIN</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>-----</b>			17. INFORMANT <b>FATHER Walter W. PARKS</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HYDROPS FETALIS</b> <b>770.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3hrs 52 min.</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>01474 5/17, 1960</b> to <b>0440 5/17, 1960</b> , that I last saw the deceased alive on <b>0440 5-17 1960</b> , and that death occurred at <b>0440 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. NAVAL HOSPITAL ANNAPOLIS, MARYLAND</b> DATE SIGNED					
ACTUAL SIGNATURE <b>Frederic M. KENNY</b>		M.D. <b>U.S. NAVAL HOSPITAL ANNAPOLIS, MARYLAND</b>			
PHYSICIAN'S NAME (Type) <b>Frederic M. KENNY LT MC USNR</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 19-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Naval Academy</b>	
22d. LOCATION (City, town, or county) <b>Annapolis</b>		22e. (State) <b>Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 20 '60</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Tayer Sons</b>		ADDRESS <b>Annapolis Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

2051353XVC



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film 3861 4/29/60 iwk

## CERTIFICATE OF DEATH

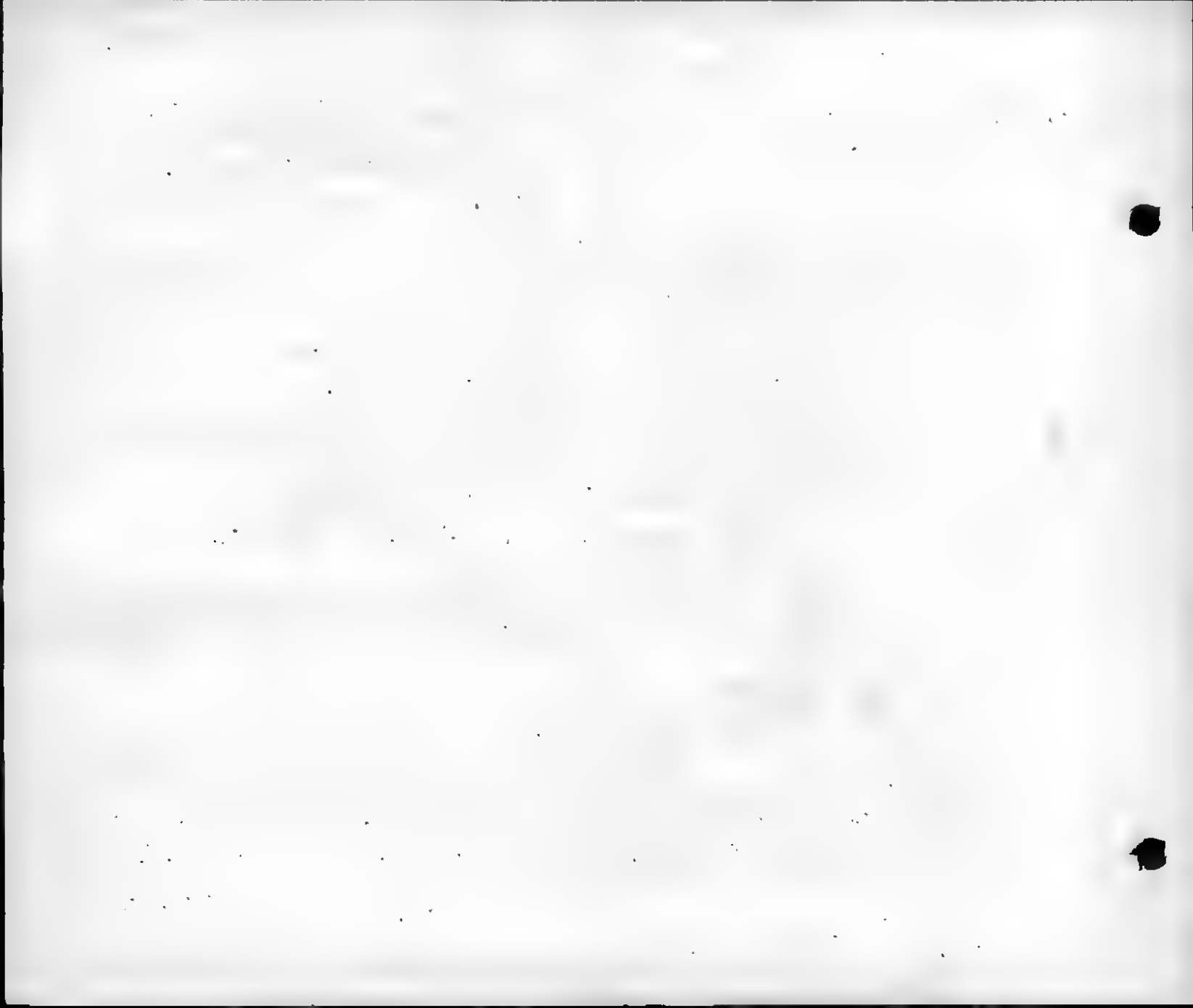
Reg. Dist. No.

04130

4200

1. PLACE OF DEATH a. COUNTY <i>Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before adm'ssion) a. STATE <i>Maryland</i> b. COUNTY <i>Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>18 Marley Neck Road, Glen Burnie Md</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>at her home-18 Marley Neck Rd.</i>		d. STREET ADDRESS <i>18 Marley Neck Rd, Glen Burnie</i>	
3. NAME OF DECEASED (Type or print) <i>LILLIAN BELL PFEIFER</i>		4. DATE OF DEATH Month <i>April</i> Day <i>23</i> Year <i>1960</i>	
5. SEX <i>Fe</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 21, 1882</i>
9. AGE (in years last birthday) <i>77</i> yrs.		10. IF UNDER 1 YEAR: Months <i>77</i> Days <i>77</i> Hours <i>77</i> Min <i>77</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Lynchburg, Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Mathew Floyd</i>		14. MOTHER'S MAIDEN NAME <i>ELLA MAY</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <i>Mrs. Vola McLaughlin</i>		Address <i>Shore Acres Arundel County</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure.</i> DUE TO (b) <i>Arteriosclerotic heart disease.</i> DUE TO (c) <i></i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Carcinoma of left breast.</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <i>o. m.</i> <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March 4, 1960</i> to <i>April 23, 1960</i> , that I last saw the deceased alive on <i>April 23, 1960</i> , and that death occurred at <i>2:15 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Edmond L. Moushalek</i> M.D.		ADDRESS (Street, city or town, state) <i>2101 S. Ritchie Highway</i> DATE SIGNED <i>4/23/60</i>	
PHYSICIAN'S NAME (Type) <i>EDMOND L. MOUSHABEK</i>		<i>Glen Burnie, Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Apr 25-60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Landon Park Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Frederick Rd Baltimore Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Benjamin G. Fink</i>		ADDRESS <i>Glen Burnie Md</i>	
24a. REC'D BY REGISTRAR <i>APR 26 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	

1  
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

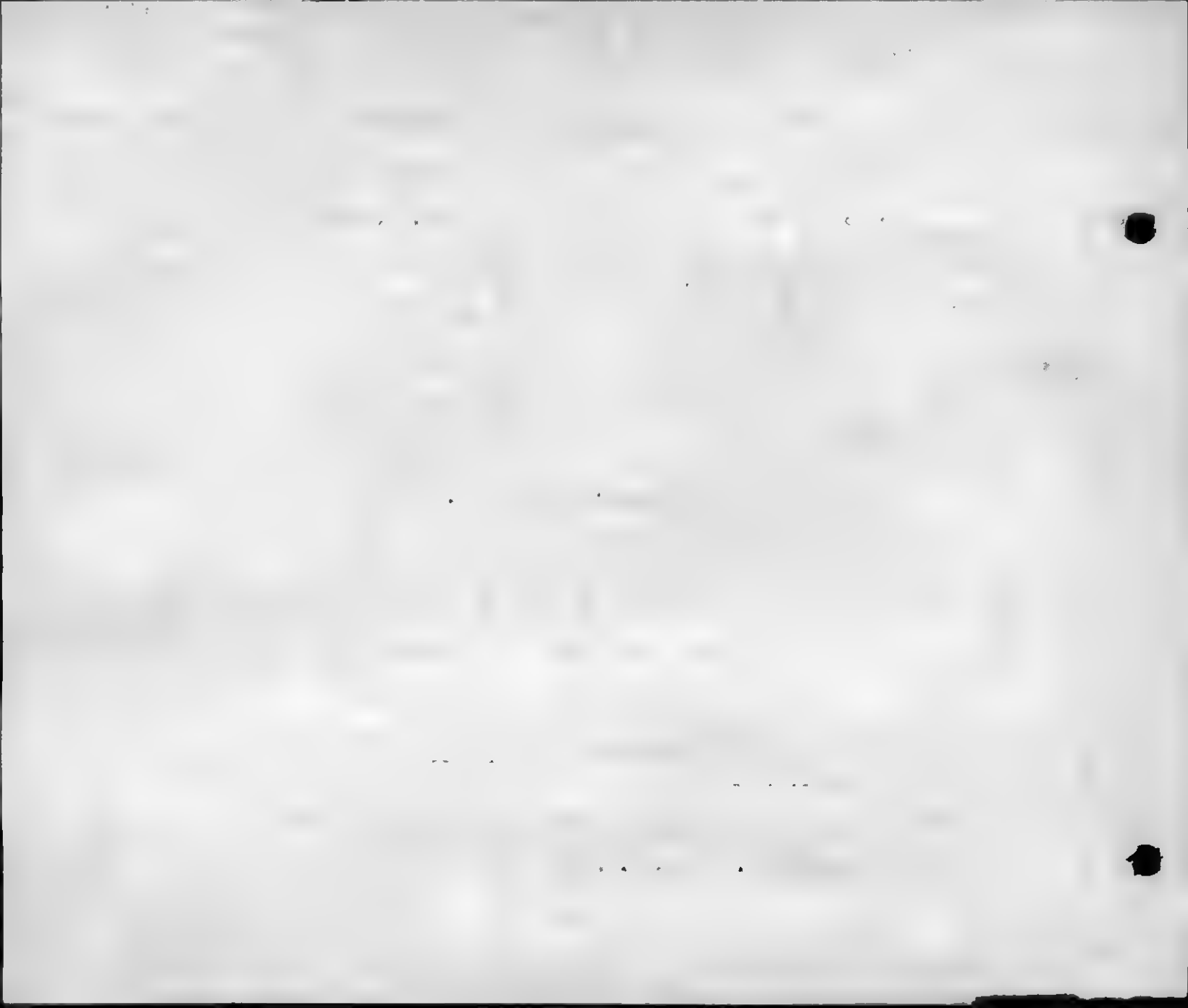


1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
4201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 64131

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rt. 1, Box 179</b>				d. STREET ADDRESS <b>Rt. 1, Box 179</b>			
3. NAME OF DECEASED (Type or print) <b>MARY</b>		First		Middle <b>ESTHER</b>		Last <b>PHILIPS</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 3, 1928</b>	
9. AGE (In years, last birthday) <b>32</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		11. BIRTHPLACE (State or foreign country) <b>Anne Arundel Co. Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>SAMUEL WILLIAMS</b>		14. MOTHER'S MAIDEN NAME <b>SADIE SHORTER</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220</b>	
17. INFORMANT <b>SADIE WILLIAMS RT 1, Box 179 Laurel</b>		Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhagic Pneumonitis.</b> 12X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles S. Petty</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>4/26/60</b>	
EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/25/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BACONS</b>		22d. LOCATION (City, town, or country) (State) <b>Anne Arundel Co. Md</b>	
23. FUNERAL DIRECTOR <b>Poizley Selby 1200 Spowden Pl</b>		ADDRESS <b>Laurel Md</b>		24a. REC'D BY REGISTRAR <b>MAY 2 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Petty</b>	



4151

## CERTIFICATE OF DEATH

64132

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>13 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Sadie</u> Middle <u>PERRY</u> Last <u>POOLE</u>				4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 14, 1881</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		11. IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>William E. Perry</u>				14. MOTHER'S MAIDEN NAME <u>Sally Crandall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>  </u> (If yes, give war or dates of service) <u>  </u>				16. SOCIAL SECURITY NO. <u>  </u>			
17. INFORMANT <u>Nelson S. Stallings 1877 Perry Grove Ave Annapolis Md.</u>				18. INTERVAL BETWEEN ONSET AND DEATH <u>13 days</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROSIS, GENERALIZED</u> DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Apr. 13, 1960</u> to <u>Apr. 26, 1960</u> , that I last saw the deceased alive on <u>April 26, 1960</u> , and that death occurred at <u>5:45 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward S. Beck</u>				ADDRESS (Street, city or town, state) <u>71 Franklin St., Annapolis, Md.</u>			
DATE SIGNED <u>4/27/60</u>				DATE SIGNED <u>4/27/60</u>			
PHYSICIAN'S NAME (Type) <u>Edward S. Beck</u>				ANNAPOLIS, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Apr. 29-1960</u>		<u>St James Cemetery</u>		<u>Tracy's Landing Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons Annapolis Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 29 '60</u>			
24b. REGISTRAR'S SIGNATURE <u>Charles S. House</u>				24c. REGISTRAR'S SIGNATURE <u>Charles S. House</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1

4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4202

CERTIFICATE OF DEATH

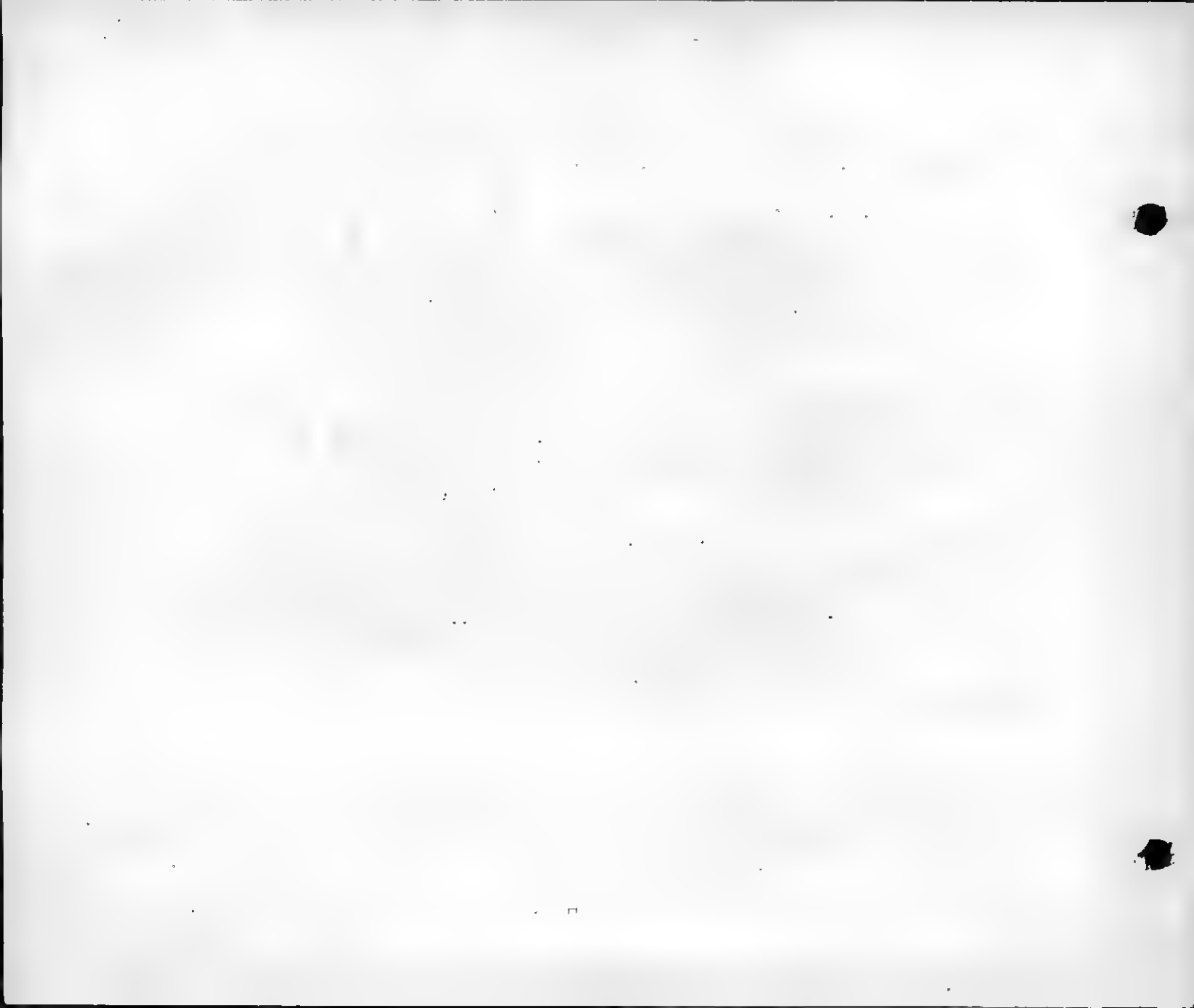
64133

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>				c. LENGTH OF STAY IN 1b <u>1 mo. 4 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u>				e. STREET ADDRESS <u>Route 2, Box 84</u>			
3. NAME OF DECEASED (Type or print) First <u>SOPHIE</u> Middle <u>PRICE</u> Last <u>PRICE</u>				4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2 December 1892</u>	
9. AGE (In years last birthday) <u>67</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Lerch</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>N/A</u>		16. SOCIAL SECURITY NO <u>Unknown</u>		INFORMANT Address <u>John Price (Husband) Rt. 2 Box 84, Severn, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Infarction, Right Long</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerotic Heart Disease with Atrial Fibrillation</u> DUE TO (c) <u>Multiple Pulmonary Emboli</u>							INTERVAL BETWEEN ONSET AND DEATH <u>30 days</u> <u>5 years</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus, Hypertensive Cardiovascular Disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>18 November, 1958</u> to <u>20 April, 1960</u> , that I last saw the deceased alive on <u>20 April, 1960</u> , and that death occurred at <u>11:20 A.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stanley Siegelman</u> M.D.						DATE SIGNED <u>20 Apr 60</u>	
PHYSICIAN'S NAME (Type) <u>STANLEY SIEGELMAN, CAPT., MC</u>						US Army Hospital, Ft George G. Meade, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-23-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert P. Ware</u> <u>Singleton Funeral Home</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 25 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4152

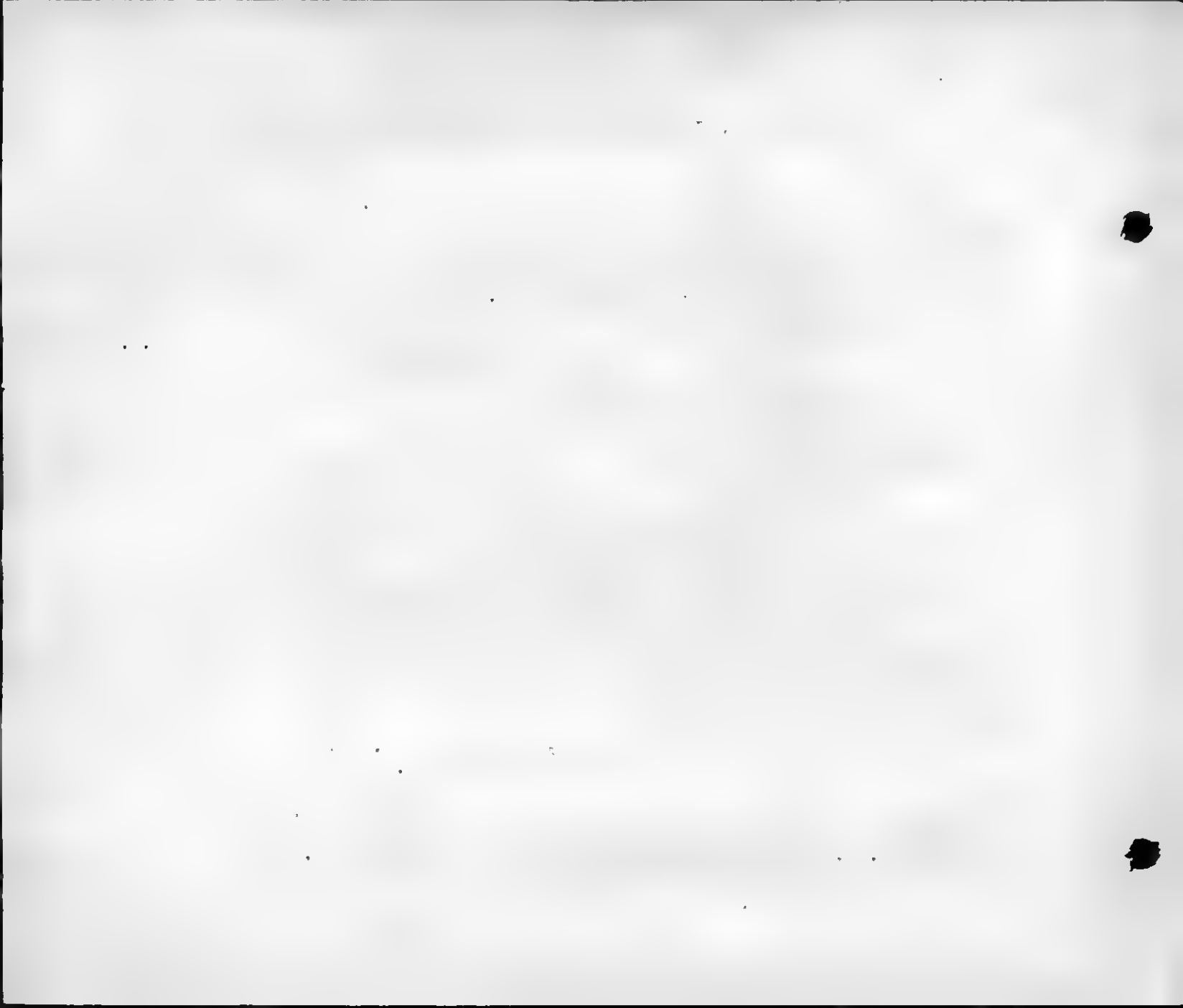
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>10</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>				1/d STREET ADDRESS <b>106 Clay St.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>James QUEEN</b>				4. DATE OF DEATH Month Day Year <b>April 27 1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 5, 1890</b>	9. AGE (In years last birthday) <b>69</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>George Queen</b>				14. MOTHER'S MAIDEN NAME <b>Louise Queen</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>219-16-0546</b>		17. INFORMANT <b>Nancy Queen</b>		Address <b>Annapolis Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>44-X</b> DUE TO <b>Is congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio Vascular Disease</b> DUE TO <b>44-X</b> (c)						INTERVAL BETWEEN ONSET AND DEATH <b>3/15 E 4/24/60</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>March 14, 1960</b> to <b>Apr. 26, 1960</b> , that I last saw the deceased alive on <b>April 26, 1960</b> , and that death occurred at <b>7:40 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>T.H. Johnson</b>				ADDRESS (Street, city or town, state) <b>37 Calvert St.,</b>		DATE SIGNED <b>4/27/60</b>	
PHYSICIAN'S NAME (Type) <b>T. H. Johnson</b>				Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-30-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Brewer Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Beckett</b>				ADDRESS <b>Annapolis Md</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 3 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>William E. Hume</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

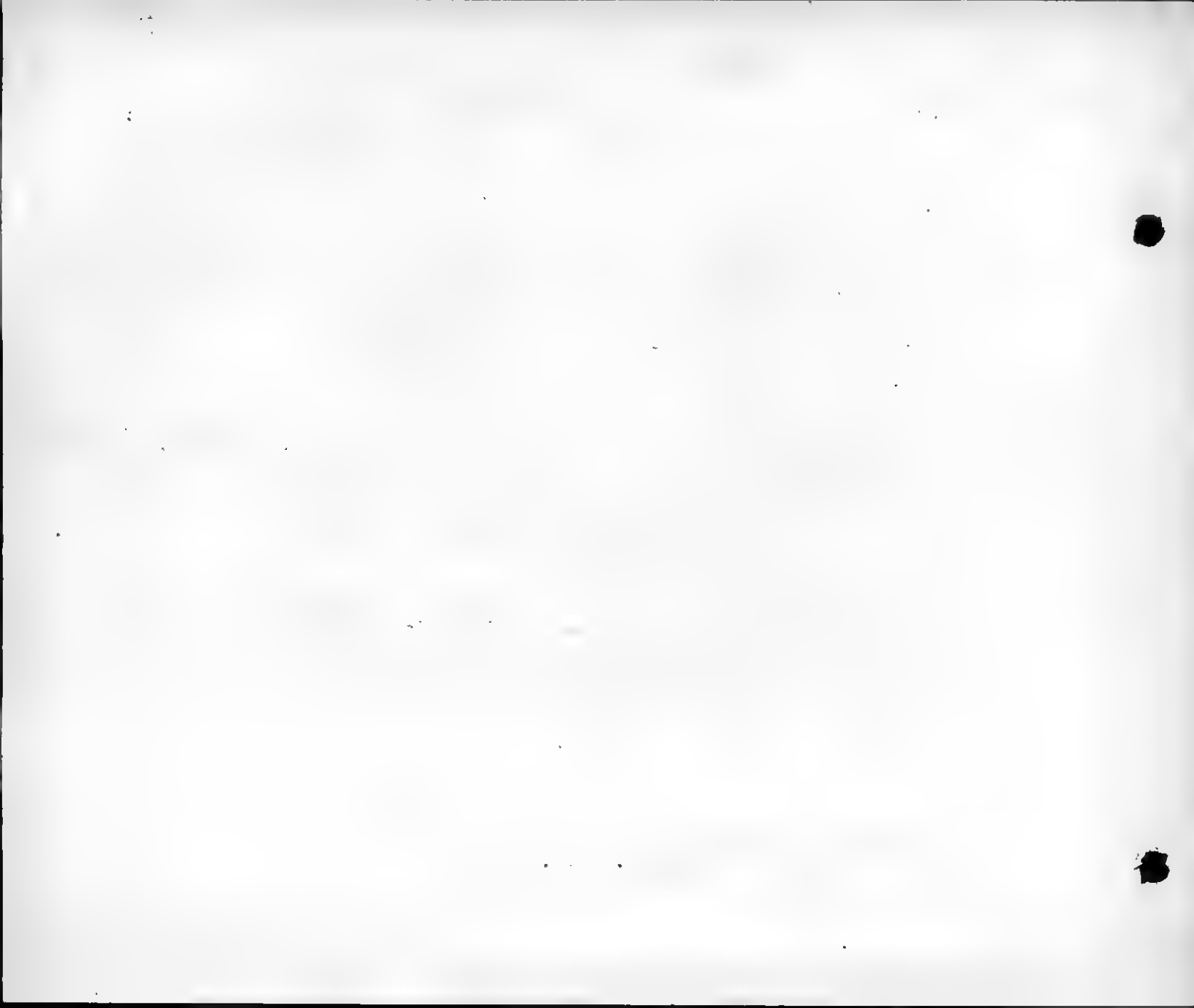


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

Item 20 Film 261 4-22-60 AMS										BALTIMORE, 18										64136																																							
4203 CERTIFICATE OF DEATH																																																											
1. PLACE OF DEATH															2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)																																												
a. COUNTY <b>Anne Arundel</b>															a. STATE <b>MARYLAND</b>																																												
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)															b. COUNTY <b>California</b>																																												
c. LENGTH OF STAY IN lb															c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)																																												
<b>Fort George G. Meade</b>															<b>San Diego</b>																																												
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION															d. STREET ADDRESS																																												
<b>U.S. Army Hospital</b>															<b>4275 Swift St</b>																																												
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																																											
3. NAME OF DECEASED (Type or print)										First										Middle										Last																													
										<b>GLADYS</b>										<b>-</b>										<b>RECORD</b>																													
4. DATE OF DEATH										Month										Day										Year																													
										<b>April</b>										<b>4</b>										<b>1960</b>																													
5. SEX					6. COLOR OR RACE					7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>					8. DATE OF BIRTH					9. AGE (In years last birthday) yrs					10. IF UNDER 1 YEAR					11. IF UNDER 24 HRS																													
<b>Female</b>					<b>Cau</b>					<b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>					<b>17 Sept 60</b>					<b>69</b>					Months					Days					Hours					Min																			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)															10b. KIND OF BUSINESS OR INDUSTRY															11. BIRTHPLACE (State or foreign country)															12. CITIZEN OF WHAT COUNTRY?														
<b>Retired</b>															<b>-</b>															<b>Nebraska</b>															<b>USA</b>														
13. FATHER'S NAME															14. MOTHER'S MAIDEN NAME																																												
<b>Unknown</b>															<b>Unknown</b>																																												
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)															16. SOCIAL SECURITY NO. (If yes, give war or dates of service)															INFORMANT															Address														
<b>-</b>															<b>-</b>															<b>(Son) Bille Record</b>															<b>US Naval Security Gp Activity Ft. Geo G Meade, Maryland</b>														
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]																																																											
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b>																																																											
904.0 DUE TO <b>Trauma to skull and bleeding diathesis</b>																																																											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>14 hrs.</b>																																																											
(c) <b>14 hrs.</b>																																																											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																																																											
<b>Polycythemia, vera with bleeding diathesis</b>																																																											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)															20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)																																												
<b>Yes</b>															<b>Fell and struck left temple</b>																																												
20c. TIME OF INJURY Month, Day, Year										20d. INJURY OCCURRED										20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)																													
<b>8:00 a.m. Apr. 4 1960</b>										<b>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/></b>										<b>Son's home</b>										<b>Ft. Geo. Meade A.A. Md.</b>																													
21. I certify that I attended the deceased from <b>4 April, 1960</b> , to <b>4 April, 1960</b> , that I last saw the deceased alive on <b>4 April, 1960</b> , and that death occurred at <b>9:45P</b> , from the causes and on the date stated above.																																																											
ACTUAL SIGNATURE <b>Nathaniel S Beard, M.D.</b>															ADDRESS (Street, city or town, state) <b>VSAH, FGLM, Md.</b>															DATE SIGNED <b>4 April 1960</b>																													
PHYSICIAN'S NAME (Type) <b>NATHANIEL S BEARD, Capt., M.C.</b>																																																											
22a. BURIAL, CREMATION, REMOVAL (Specify)										22b. DATE THEREOF										22c. NAME OF CEMETERY OR CREMATORY										22d. LOCATION (City, town, or county) (State)																													
<b>Burial</b>										<b>4/11/60</b>										<b>San Diego California</b>										<b>San Diego California</b>																													
23. FUNERAL DIRECTOR'S SIGNATURE															ADDRESS															24a. REC'D BY REGISTRAR										24b. REGISTRAR'S SIGNATURE																			
<b>De Witt Donaldson Laurel Md</b>															<b>De Witt Donaldson Laurel Md</b>															<b>DATE APR 8 '60</b>										<b>Arthur L. Kraus</b>																			



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

64137

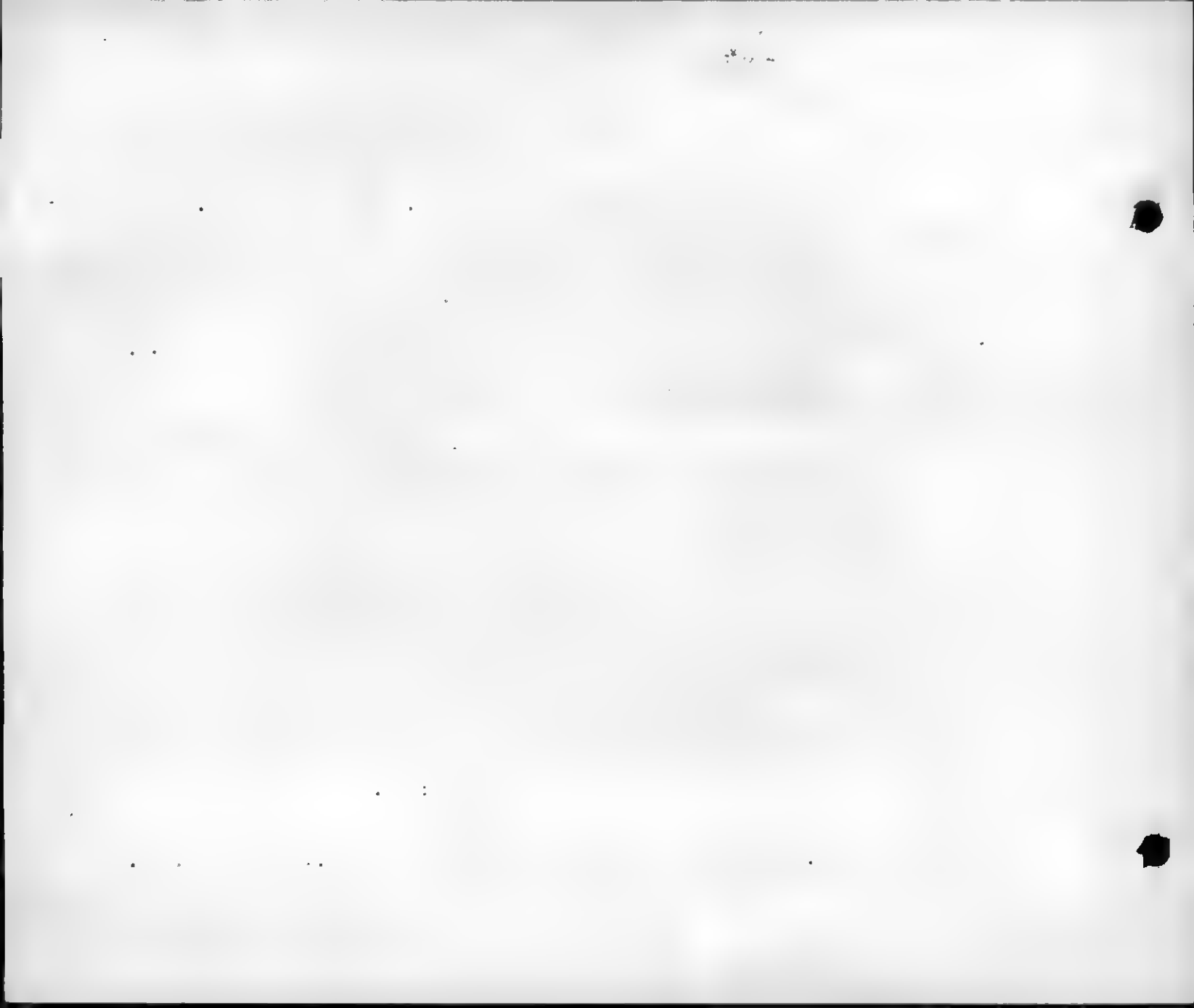
**CERTIFICATE OF DEATH**

4153

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>5 S. Cherry Grove Ave.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Mabel</b> Middle <b>SCHOTT</b> Last <b>SCHOTT</b>				4. DATE OF DEATH Month <b>April</b> Day <b>16</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 12, 1889</b>	
9. AGE (In years last birthday) <b>70</b> yrs		10. IF UNDER 1 YEAR Months <b>70</b> Days <b>0</b> Hours <b>0</b> Min.		11. IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>George Nlman</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>				16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Charles H. Schott</b> Address <b>-</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma of cervix</b> DUE TO <b>171X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>-</b> DUE TO <b>-</b> (c) <b>-</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>-</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 19 55</b> to <b>April 16 1960</b> , that (I) (we) last saw the deceased alive on <b>April 16 1960</b> , and that death occurred at <b>11:40A.</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>John L. Hedeman</b>				M D ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>4/18/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>John L. Hedeman</b>				22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 20 - 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>National Cent</b>		23d. LOCATION (City, town, or county) (State) <b>Annapolis Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor</b>				25a. REC'D BY REGISTRAR DATE <b>APR 20 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





4165 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne A. Mel MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE Annapolis b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Severna Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Old Annapolis Road				/ d. STREET ADDRESS Old Annapolis Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Harry Melling SHALLET				4. DATE OF DEATH Month Day Year April 3 19 60			
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1882	9. AGE (In years lost birthday) 78 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk		10b. KIND OF BUSINESS OR INDUSTRY General Office		11. BIRTHPLACE (State or foreign country) NYC		12. CITIZEN OF WHAT COUNTRY? yes USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) no 064 09 7045		INFORMANT Address Mrs. Elizabeth M. Sharkey- Wife- same as # 2			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular hemorrhage 33/X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO 1. Generalized arteriosclerosis. (c)						INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 56 to April 19 60, that I last saw the deceased alive on April 1 19 60 and that death occurred at 6 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 4-4-60 ACTUAL SIGNATURE Francis I. Codd M.D. PHYSICIAN'S NAME (Type) Severna Park, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 6, 1960		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hopping Funeral Home Annapolis, Maryland				24a. REC'D BY REGISTRAR DATE APR 6 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kneale	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1864139

## 4154 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film G2004/17/601b

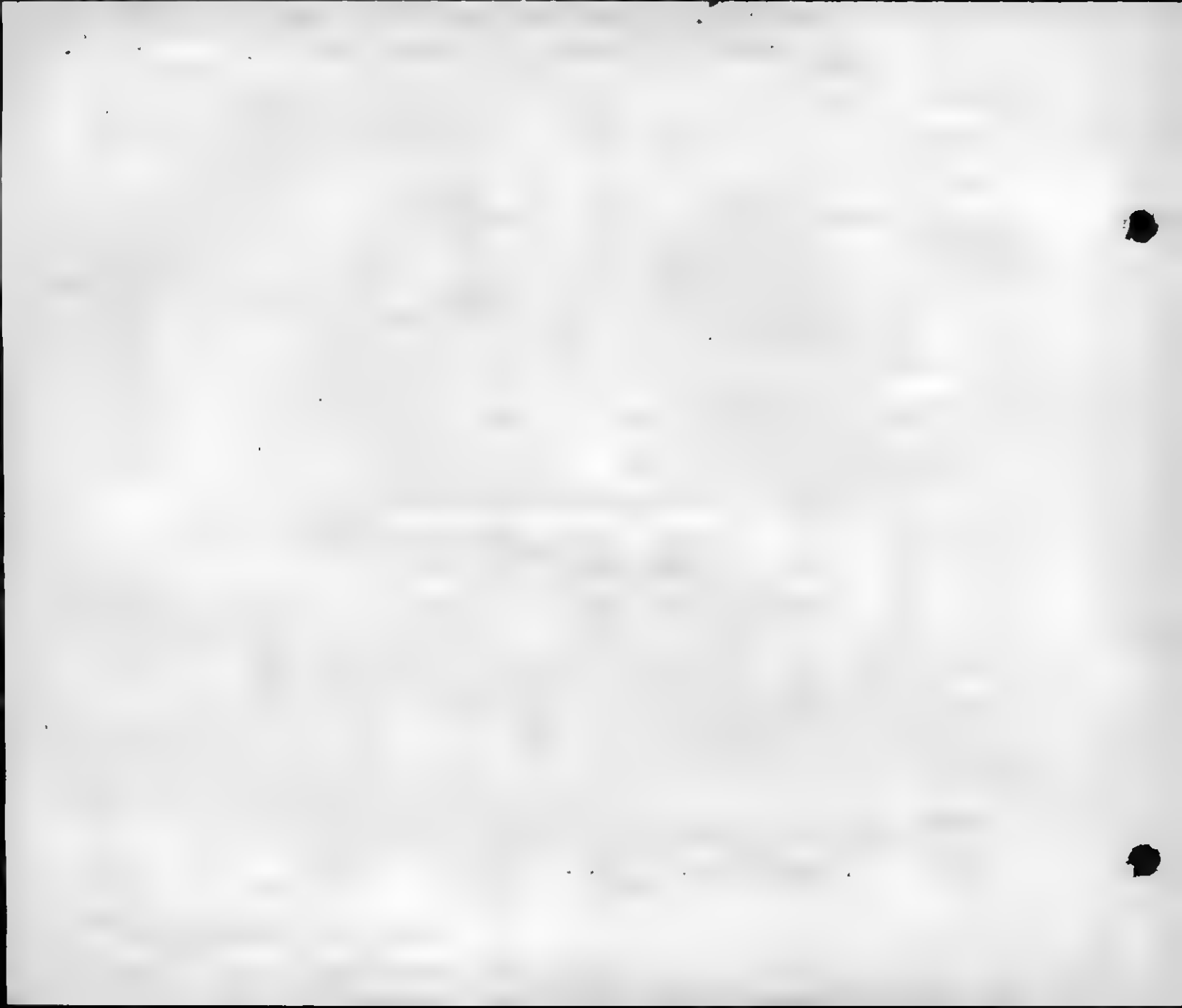
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN 1b <b>Annopolis</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annopolis</b> /d. STREET ADDRESS <b>830 Chester Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Myrtle</b> Middle <b>Virginia</b> Last <b>Shelton</b>		4. DATE OF DEATH Month <b>April</b> Day <b>2</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Wh</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/10/07</b>
9. AGE (in years last birthday) <b>52</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>	11. BIRTHPLACE (State or foreign country) <b>DEALE MD</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>CHARLES FORD</b>	
14. MOTHER'S MAIDEN NAME <b>MARY LLOYD</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b> (If yes, give war or dates of service) <b>-</b>	
16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>R. VERNON SHELTON</b> Address <b>(2)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Maddive Internal Hemorrhage</b> DUE TO <b>977X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Stab wound of abdomen, with transection of right common iliac artery</b> DUE TO <b>right common iliac artery</b> (c) <b>-</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>-</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>-</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Stabbed self in abdomen with kitchen knife</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>4/2</b> <b>1960</b> p. m. <b>-</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) <b>Annopolis, Anne Arundel, Md.</b> (County) <b>-</b> (State) <b>-</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>W. Bradley King, Jr.</b>		DATE SIGNED <b>April 3, 1960</b>	
EXAMINER'S NAME (Type) <b>W. Bradley King, Jr. M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Crema</b>	22b. DATE THEREOF <b>Apr 5 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cem</b>	22d. LOCATION (City, town, or county) <b>Annopolis Md</b> (State) <b>-</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor Sr</b> ADDRESS <b>Annapolis Md</b>		24a. REC'D BY REGISTRAR <b>APR 6 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Carlton E. Kraus</b>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any doubt is necessary, please enclose this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



4155

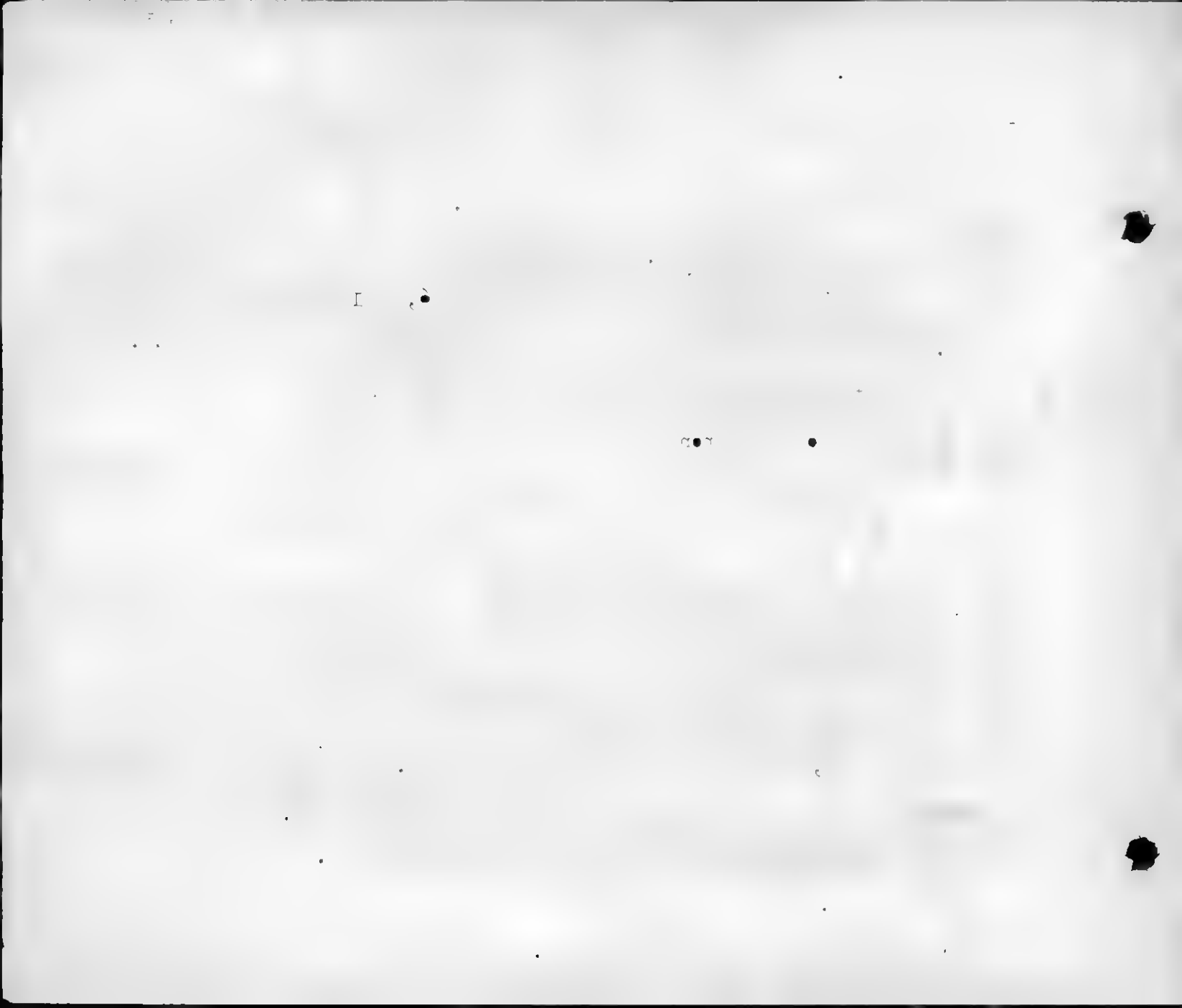
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>9 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - Annapolis</b>	
		f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>A.</b> Last <b>SIMMONS</b>		4. DATE OF DEATH Month <b>April</b> Day <b>26</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 6, 1870</b>
9. AGE (In years last birthday) <b>89 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Robert Simmons</b>		14. MOTHER'S MAIDEN NAME <b>Ellen ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs Ella Simmons</b>		Address <b>Wife same as # 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Atrophy &amp; psychosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized and localized convulsions</b> DUE TO (c) <b>Similarity</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fall down steps 6 wks. ago</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 3, 1960</b> to <b>April 25, 1960</b> , that I last saw the deceased alive on <b>April 25, 1960</b> , and that death occurred at <b>3:15 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Maurice Klawans</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>31 Southgate Ave., Annapolis, Md. 4/26/60</b>	
PHYSICIAN'S NAME (Type) <b>Maurice Klawans</b>		<b>Annapolis, Md.</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Apr. 28, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Memorial</b>	22d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>		ADDRESS <b>Annapolis, Md.</b>	24a. REC'D BY REGISTRAR DATE <b>APR 29 '60</b>
		24b. REGISTRAR'S SIGNATURE <i>Charles L. Kraw...</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

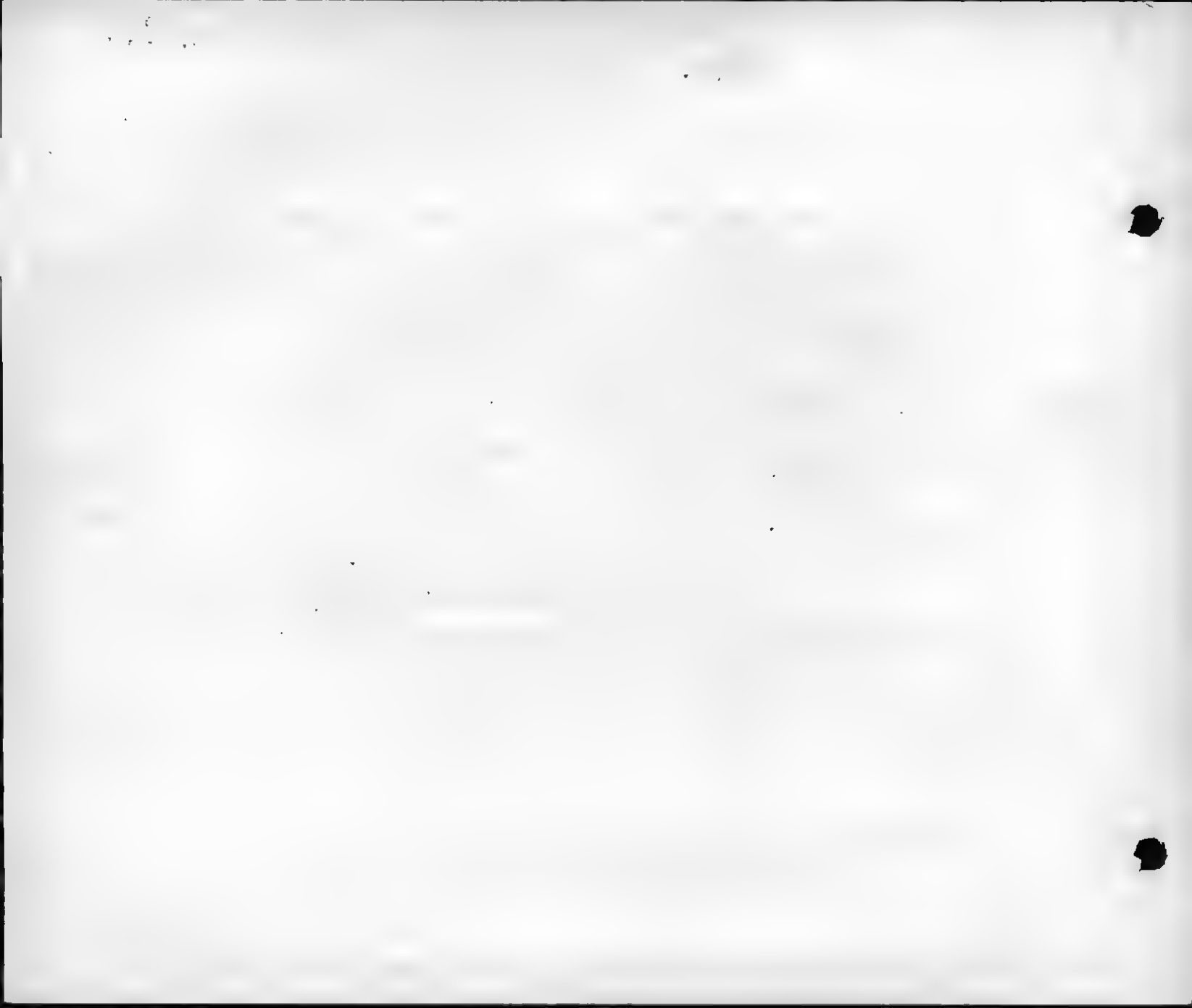


may be returned by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**4204 CERTIFICATE OF DEATH**

04141

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel (Rural)</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Barbers Trailer Court</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clarice Dail Smith</u>				4. DATE OF DEATH Month Day Year <u>April 2 1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 2, 1905</u>		9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cash Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Taxicab</u>		11. BIRTHPLACE (State or foreign country) <u>Charlottesville W Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Smith</u>				14. MOTHER'S MAIDEN NAME <u>Emmie Marie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>235-18-7059</u>		17. INFORMANT <u>John Smith, Laurel, Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE OF <u>480X</u> DUE TO <u>Influenza</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>1</u> DUE TO <u>Bronchopneumonia</u> <u>2</u> DUE TO <u>Bronchial Asthma</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>3 days</u> <u>5 Mon-</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatic Cardiovascular Disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>3/28</u> 19 <u>60</u> to <u>4/2</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>4/2</u> 19 <u>60</u> and that death occurred at <u>5AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>J. M. Warren</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>J. M. WARREN</u>				22d. ADDRESS <u>Laurel Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 4, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Old Fellows Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Charlottesville W. Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Carraldon</u> ADDRESS <u>Laurel, Md</u>				25a. REC'D BY REGISTRAR <u>Apr 8 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Claudia S. Hines</u>	





4205 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>A.B.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. LENGTH OF STAY IN 1b <b>6</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>318 Milton Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Marie Smith</b>		4. DATE OF DEATH <b>April 28, 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 22, 1907</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Balto. Md.</b>	
13. FATHER'S NAME <b>William Tudor</b>		14. MOTHER'S MAIDEN NAME <b>Sophie Bowers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO. <b>213-03-4940</b>	
17. INFORMANT <b>Louis Smith-318 Milton Ave.</b>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO <b>Metastatic carcinoma of lumbar spine</b> left chest wall. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <b>Duct cell carcinoma of left breast.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>5 months</b> <b>5 years</b>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <b>Oct. 11, 1955</b> to <b>April 28, 1960</b> that I last saw the deceased alive on <b>April 27, 1960</b> , and that death occurred at <b>4:20 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>11 E. Chase Street</b> DATE SIGNED <b>April 28, 1960</b> ACTUAL SIGNATURE <b>Dwight M. Currie</b> M.D. PHYSICIAN'S NAME (Type) <b>Dwight M. Currie M.D.</b> <b>Baltimore 2, Md.</b>	
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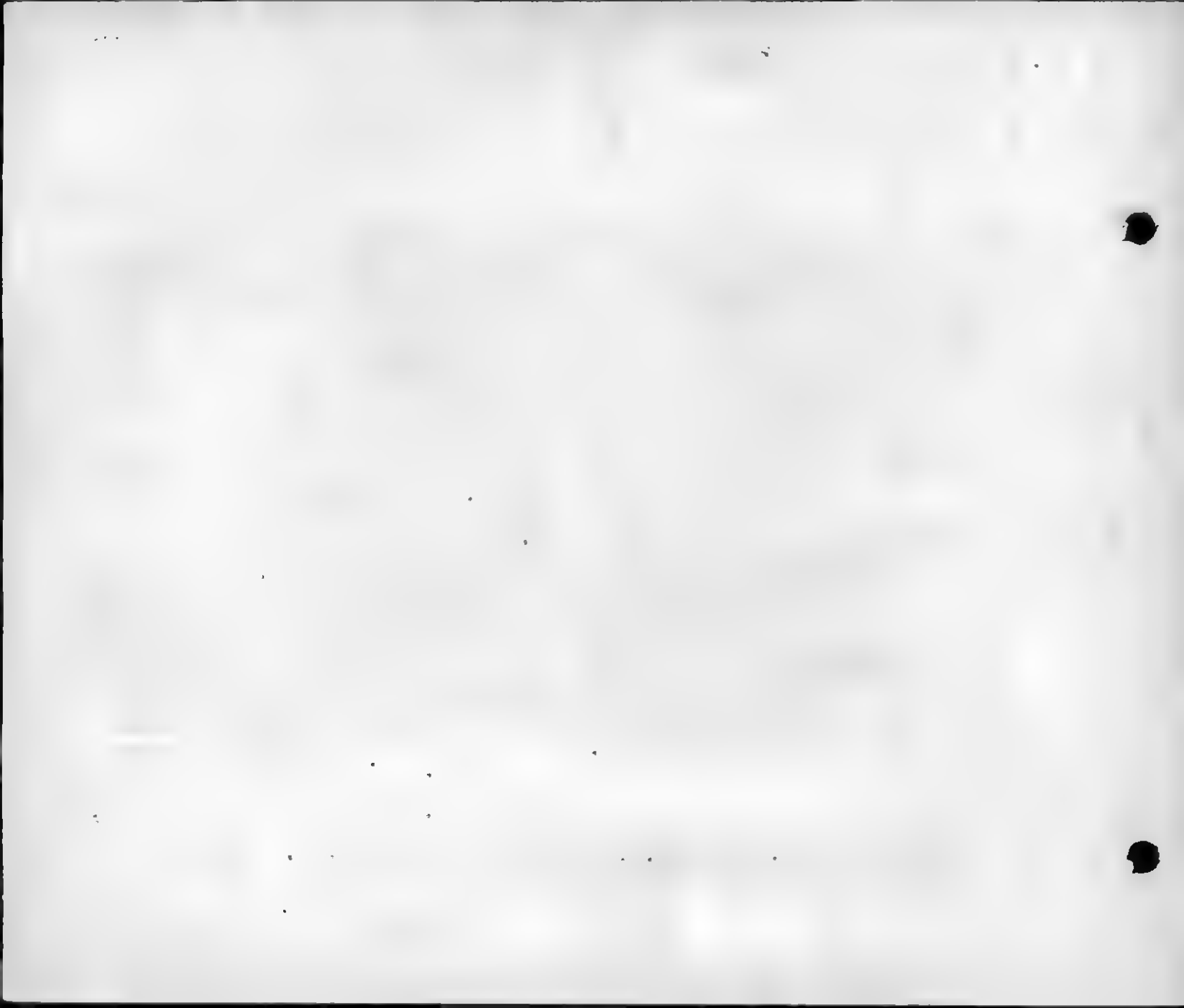
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-2-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>
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23. FUNERAL DIRECTOR'S SIGNATURE <b>John P. Kelly</b>	ADDRESS <b>2431 E. Oliver St.</b>	24a. REC'D BY REGISTRAR DATE <b>5/2/60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Haines</b>
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10 3446

MAY 4 '60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4156

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64143

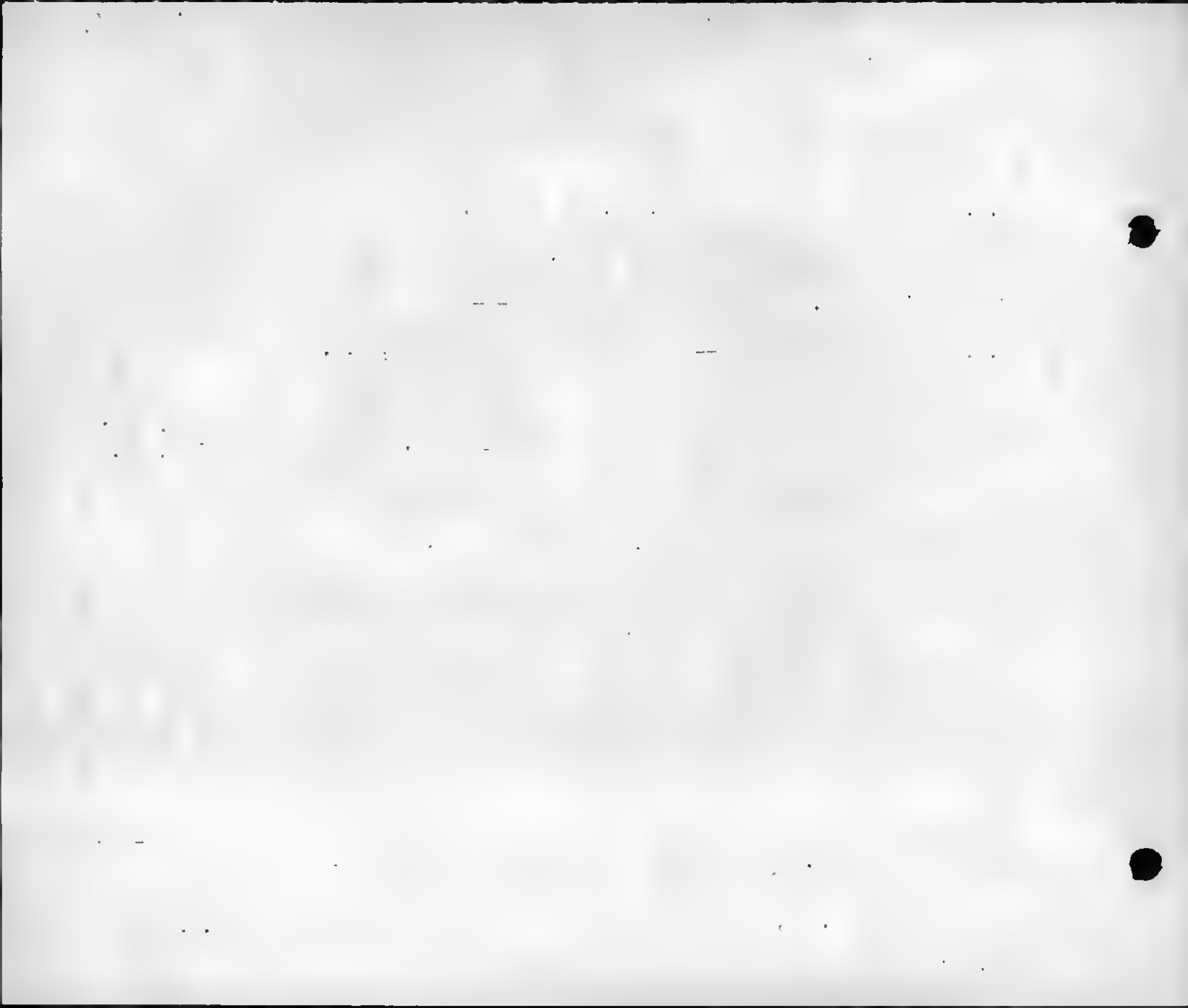
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>				c. LENGTH OF STAY IN TB <b>DOA</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Harry Carl SORGNIT</b>				4. DATE OF DEATH Month Day Year <b>April 19 1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-8-85</b>	9. AGE in years (last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. NAVY RETIRED</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>		
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>KARL SORGNIT</b>				14. MOTHER'S MAIDEN NAME <b>CHRISTINE HENNIGE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Son: Elwood C. Sorgnit</b>		Address <b>309 N. Woodlawn Annapolis, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Arteriosclerosis, Severe</b> DUE TO (c) <b>---</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Benign Nephrosclerosis, Generalized Arteriosclerosis</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Elmer G. Linhardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Elmer G. Linhardt</b>		DATE SIGNED <b>4-19-60</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 21, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hopping Funeral Home</i>				ADDRESS <b>Annapolis, Maryland</b>		24c. REC'D BY REGISTRAR <b>DATE APR 22 '60</b>	
				24b. REGISTRAR'S SIGNATURE <i>Charles E. Hanna</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



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VR A15 (4)  
15M 9/59

4208 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
Item 22 - 11-1-60-01-01-01

04144

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore - 25</b> c. LENGTH OF STAY IN 1b <b>60 yrs</b>		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Anne Arundel Co.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>50 Baltimore - 25</b> d. STREET ADDRESS <b>416 E. Seward Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Josefa (Josephine) Sramek</b>		4. DATE OF DEATH Month Day Year <b>April 23, 1960 19</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 27, 1878</b>
9. AGE (in years lost birthday) <b>81 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min <b>2 years</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Czechoslovakia</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Mr. Pacholik</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>(If yes, give war or dates of service)</b>	
17. INFORMANT <b>Mrs. Harry Garreis, 416 E. Seward Ave.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Central Thromboses</b> DUE TO <b>Arteriosclerotic C.V. disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>DUE TO</b> (c) <b>2 years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>2 years</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1957</b> to <b>April 22, 1960</b> , that (I) (we) last saw the deceased alive on <b>April 22, 1960</b> , and that death occurred at <b>8:45 PM</b> , from the causes and on the date stated above			
22a. SIGNATURE <b>Sidney R. Gehlert</b>		22b. DATE SIGNED <b>April 22, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>SIDNEY R. GEHLERT</b>		22d. ADDRESS <b>4700 Pimlico Ave</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 26, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Anne Arundel Co., Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>George J. Gonce, 4001 Ritchie Hwy., (25)</b>		25a. REC'D BY REGISTRAR DATE <b>APR 29 '60</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>	









4208

## CERTIFICATE OF DEATH

04147  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St Margarets</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St Margarets R. 7 D.</u>				e. STREET ADDRESS <u>St Margarets R. 7 D.</u>			
3. NAME OF DECEASED (Type or print) <u>W. Nathan Strong Tyler</u>				4. DATE OF DEATH Month <u>4</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 4<sup>th</sup> 1895</u>	9. AGE (In years last birthday) <u>64</u> yrs	IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS: Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Westwood N. J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Conrad M. Strong</u>				14. MOTHER'S MAIDEN NAME <u>Frances Perry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>George T. Tyler</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cute myocardial infarction.</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u>Unknown</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>4/2</u> , 19 <u>60</u> , to <u>4/2</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>19</u> and that death occurred at <u>9:05</u> A. M. from the causes and on the date stated above.							
Actual Signature <u>Chas E Dr. Linhardt</u>				ADDRESS (Street, city or town, state) <u>Md. - Westminster</u>		DATE SIGNED <u>4/2/60</u>	
PHYSICIAN'S NAME (Type) <u>Chas E Dr. Linhardt</u>				M.D. <u>121 Cathedral</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr - 5 - 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Lebanon Cem</u>		22d. LOCATION (City, town, or county) <u>Winchester</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>				ADDRESS <u>2000 Connopole Rd</u>		24a. REC'D BY REGISTRAR DATE <u>APR 6 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

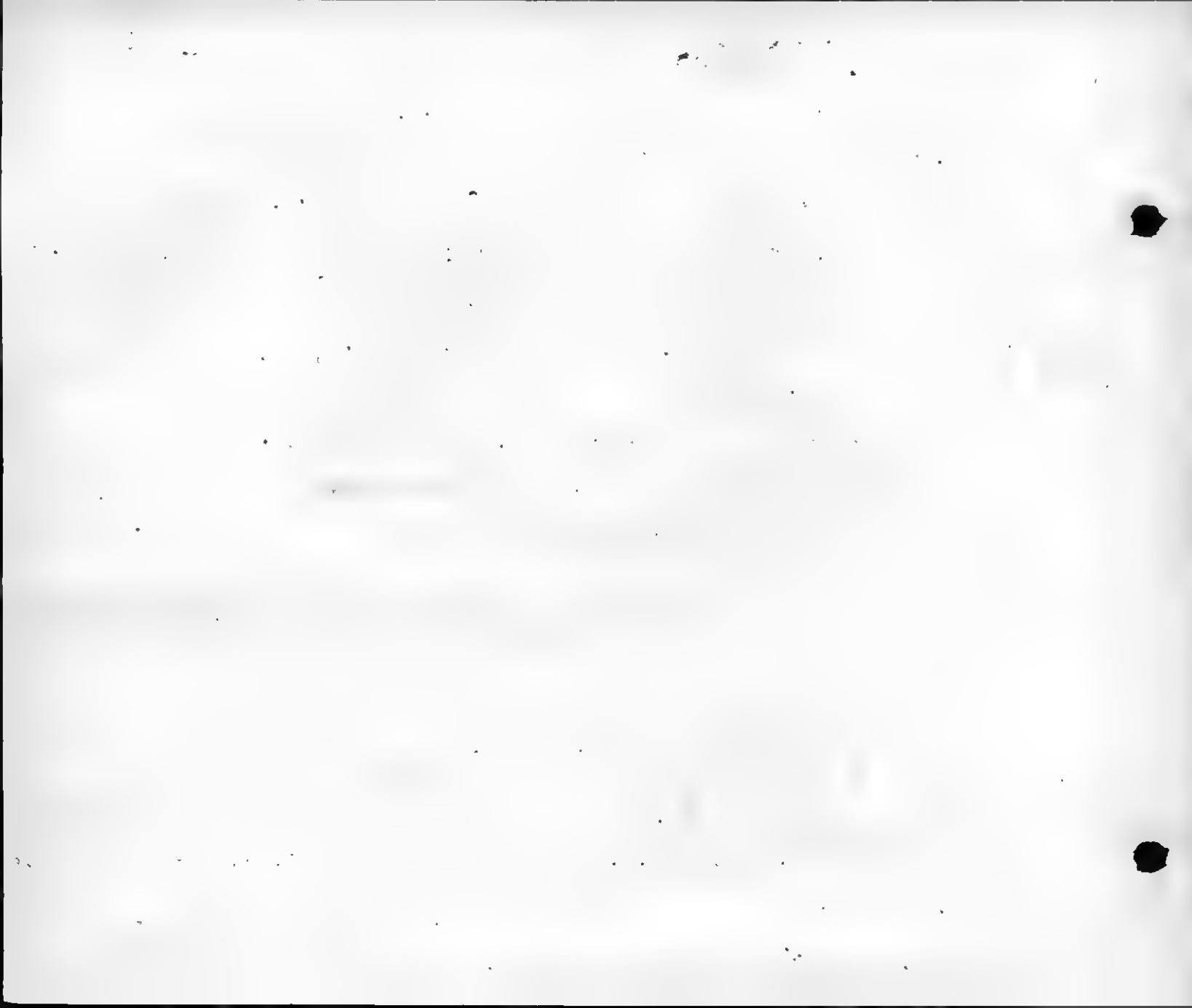


4157 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN 1b <b>DOA</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>AA General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>AA</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>60 Glen Burnie</b> d. STREET ADDRESS <b>1 206 B &amp; A Blvd. NW</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Dorothy</b> Middle <b>Ellen</b> Last <b>Wagner</b>		4. DATE OF DEATH Month <b>April</b> Day <b>25</b> Year <b>19 60</b>	
5. SEX <b>Fema le</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/29/16</b>
9. AGE (In years last birthday) <b>43</b> yrs		10. IF UNDER 1 YEAR Months <b>43</b> Days <b>43</b> Hours <b>43</b> Min <b>43</b>	11. IF UNDER 24 HRS Months <b>43</b> Days <b>43</b> Hours <b>43</b> Min <b>43</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Glen Burnie, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>George Harding</b>	
14. MOTHER'S MAIDEN NAME <b>Lilly Ruby</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>213-20-8857</b>		INFORMANT Address <b>Mr. Thomas Wagner, same as 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>GASTRO-INTESTINAL HEMORRHAGE</b> DUE TO (b) <b>METASTATIC MELANOMA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>24 hrs.</b> <b>2 MOS.</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>7-12</b> , 19 <b>55</b> , to <b>4-25</b> , 19 <b>60</b> , that I lost sown the deceased alive on <b>4-25</b> , 19 <b>60</b> , and that death occurred at <b>7:15P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>201 B &amp; A Blvd. NW, Glen Burnie</b> DATE SIGNED <b>4-26-60</b>			
ACTUAL SIGNATURE <b>Leon C. Perry</b> M.D.		PHYSICIAN'S NAME (Type) <b>Leon C. Perry, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/29/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial</b>	22d. LOCATION (City, town, or county) (State) <b>Glen Burnie, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping and Kirkley, Glen Burnie, Md.</b>		24a. REC'D BY REGISTRAR <b>APR 29 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>

1  
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 64149

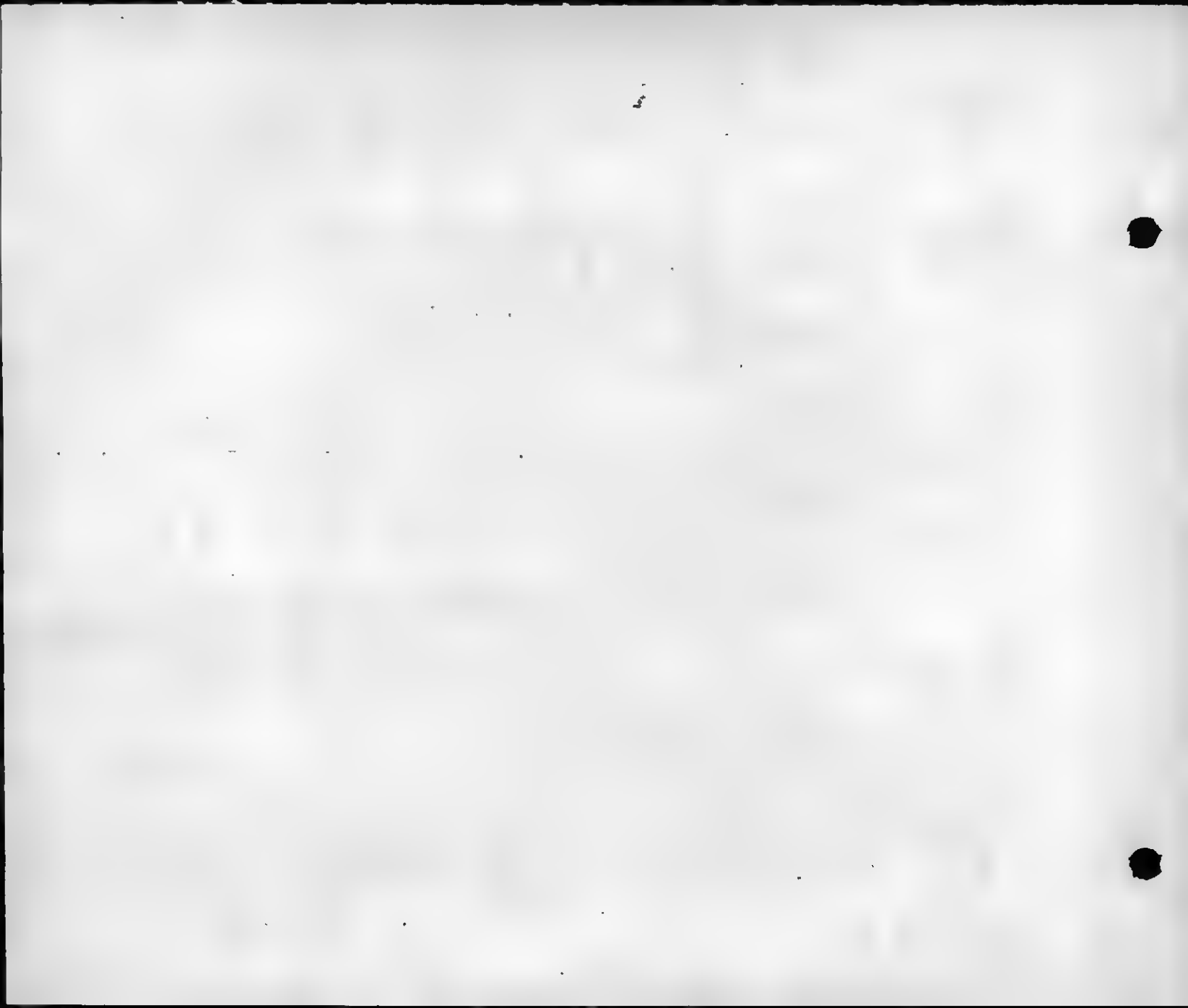
## 4158 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>10</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>69 West Street</u>				d. STREET ADDRESS <u>69 West Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Eckard</u> Middle <u>W.</u> Last <u>Walton</u>				4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>19 60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1906</u> <u>Jan. 8, 1906</u>	9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House painting (self employed)</u>		11. BIRTHPLACE (State or foreign country) <u>Bristol</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Walton</u>				14. MOTHER'S MAIDEN NAME <u>Maggie Markus</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>215 12 4298</u>		17. INFORMANT <u>Mrs. Clara Greenwell- Sister- Annapolis, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.4</u> DUE TO <u>Cardiac Lesion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> DUE TO <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Elmer G. Linhardt</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Elmer G. Linhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 4, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Annapolis National Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopkins Funeral Home</u>				24a. REC'D BY REGISTRAR DATE <u>APR 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO DEF. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any certificate is necessary, please enclose this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

4159

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

64150

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>3 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mildred</b> Middle <b>Dove</b> Last <b>WAYSON</b>				4. DATE OF DEATH Month <b>April</b> Day <b>7</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 11, 1875</b>	
9. AGE (In years last birthday) <b>85 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>FRANKLIN DOVE</b>				14. MOTHER'S MAIDEN NAME <b>ALICE HUMPHREY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO <b>—</b>		17. INFORMANT Address <b>MRS NORMAN SHEPHERD (2)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction.</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>April 4, 1960</b> to <b>April 7, 1960</b> , that (I) (we) last saw the deceased alive on <b>April 7, 1960</b> , and that death occurred at <b>—</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Richard N. Peeler</b>				22b. DATE SIGNED <b>4/7/60</b>		22c. PHYSICIAN'S NAME (Type) <b>Richard N. Peeler</b>	
22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>4-9-1960</b>		<b>Mt Zion Cemetery</b>		<b>Mt Zion Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor Sr</b>				25a. REC'D BY REGISTRAR DATE <b>APR 12 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frame</b>	

422.2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
SM 9/59

1

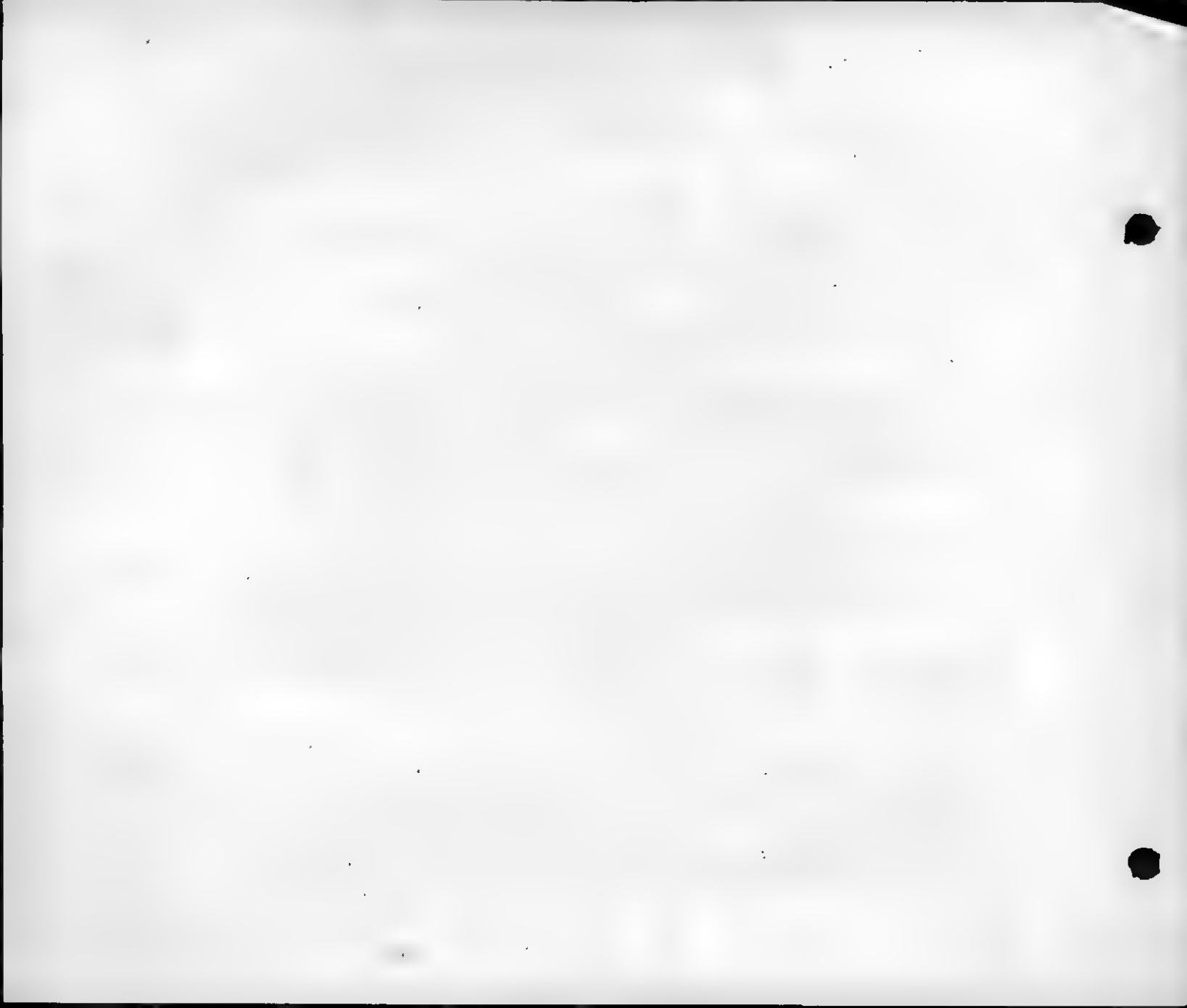
4160

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
64151

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>AA</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Davidsonville, Maryland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				e. STREET ADDRESS <b>1</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Lawrence</b> Last <b>White</b>				4. DATE OF DEATH Month <b>April</b> Day <b>1</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 27, 1960</b>	
9. AGE (In years lost birthday) <b>3</b> yrs		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>5</b> Hours <b>5</b> Min <b>5</b>		11. BIRTHPLACE (State or foreign country) <b>Annapolis Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>			
13. FATHER'S NAME <b>Oscar Sylvester White</b>				14. MOTHER'S MAIDEN NAME <b>Veronica Ann Holidayske</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO <b>—</b>		17. INFORMANT <b>Oscar S. White</b>		Address <b>(2)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>754.7</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) <b>Transportation of preterminal</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3-27-1960</b> to <b>4-1-1960</b> that (I) (we) last saw the deceased alive on <b>4-1-1960</b> and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above							
22a. SIGNATURE <b>Clayton Norton</b>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4-3-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Clayton Norton</b>		22d. ADDRESS <b>Sevenson Park, Md</b>					
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr 4<sup>th</sup> 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St Marys Court</b>		23d. LOCATION (City, town, or county) (State) <b>Annapolis MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor</b>		ADDRESS <b>Annapolis Md.</b>		25a. REC'D BY REGISTRAR <b>APR 6 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

206323



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4161 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64152

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		d. STREET ADDRESS <u>117 5th Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>117 5th Street</u>				e. IS RESIDENT ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Vermon</u> Last <u>Williams</u>				4. DATE OF DEATH Month <u>7</u> Day <u>3</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-20-1917</u>	
9. AGE (In years last birthday) <u>42</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Troy, N.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Harvey Williams</u>		14. MOTHER'S MAIDEN NAME <u>Marj Harried</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>No</u>		16. SOCIAL SECURITY NO		17. INFORMANT <u>John Williams - Annapolis, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tuberculosis</u> DUE TO (b) <u>Epilepsy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> e. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. L. Linhardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. L. Linhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>4/7/60</u>			
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-9-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pine Lawn</u>		22d. LOCATION (City, town, or county) (State) <u>Besgate, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. Annapolis, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 13 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

MEDICAL CERTIFICATION

X 800

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4209 CERTIFICATE OF DEATH

64153

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>				c. LENGTH OF STAY IN 1b <b>6 yrs. 1mo. 23 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>312 Howard Place</b>			
3. NAME OF DECEASED (Type or print) <b>Estella</b>				4. DATE OF DEATH Month <b>4</b> Day <b>28</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 12, 1890</b>	
9. AGE (In years last birthday) <b>69</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY -----			
13. FATHER'S NAME <b>Dennis Jones</b>				14. MOTHER'S MAIDEN NAME <b>Florence Ford</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost (c) <b>Decubital Ulcers</b> <b>Arteriosclerotic Hypertensive Cardiovascular disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) -----			
20c. TIME OF INJURY Hour a. m. ----- p. m. <b>19</b>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) -----	
20f. (City or town) -----				20g. (County) -----		20h. (State) -----	
21. I certify that (I) (this hospital) attended the deceased from <b>3/5</b> <b>1960</b> to <b>4/28</b> <b>1960</b> , that (I) (we) last saw the deceased alive on <b>4/28</b> <b>1960</b> , and that death occurred at <b>3:55</b> A. M. from the causes and on the date stated above							
22a. SIGNATURE <b>Hildegard Heard Reissman, M. D.</b>				22b. DATE <b>4/28/60</b>		22c. PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissman, M. D.</b>	
22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>				22e. REC'D BY REGISTRAR <b>MAY 2 '60</b>		22f. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	
23a. (BURIAL/CREMATION, REMOVAL) (Specify) <b>4/30/60</b>		23b. DATE THEREOF <b>4/30/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cumberland Md</b>		23d. LOCATION (City, town, or county) (State) <b>md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Thos. J. ...</b>							



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04154

Reg. Dist. No.

4210

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>P.O. Pasadena</b> c. LENGTH OF STAY IN lb <b>20 hours</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>On the pier extending from the home of Mr. E. Voss, BaySide Beach.</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>1</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 27</b> d. STREET ADDRESS <b>5207 Carroll Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>John Carlton Willis</b>				4. DATE OF DEATH Month Day Year <b>April 23rd. 1960 19</b>			
5. SEX <b>M.</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/23/17</b>	
9. AGE (In years last birthday) <b>42 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Office Clerk</b>		11. BIRTHPLACE (State or foreign country) <b>Wachapreague, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John E. Willis</b>				14. MOTHER'S MAIDEN NAME <b>Minnie Richardson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Navy 1940-45</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Mary Willis, (wife)</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO DUE TO						INTERVAL BETWEEN ONSET AND DEATH <b>Sydden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Gustave H. Faubert, MD.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Gustave H. Faubert, MD.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>4/23/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>26 Apr. 60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wachapreague Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Wachapreague, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping &amp; KIRKLEY, E. P. BOWNE, MD.</b>				24a. REC'D BY REGISTRAR DATE <b>APR 26 '60</b>		24b. REGISTRAR'S SIGNATURE <b>William S. H. King</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

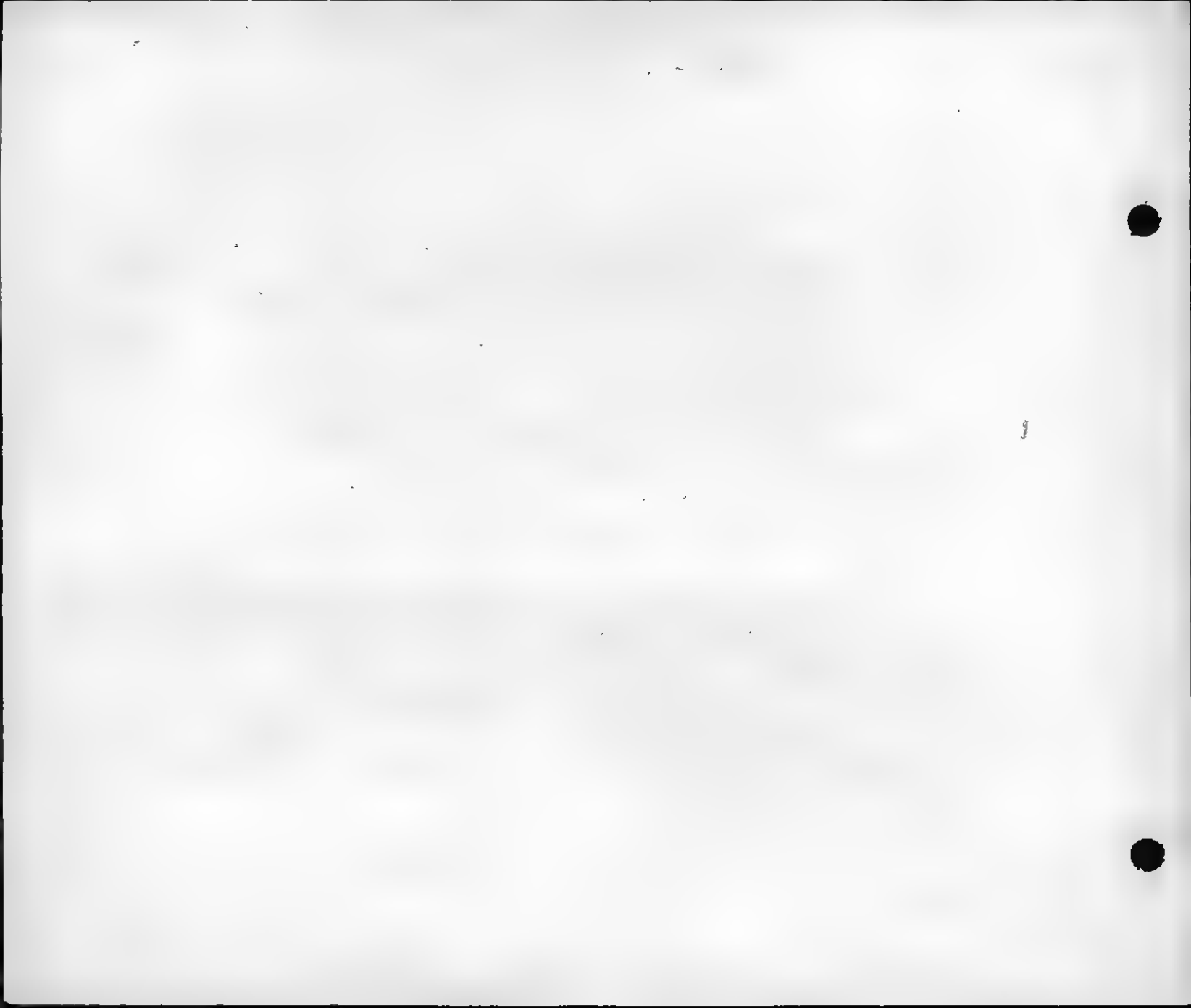
4211

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

64155

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ST. MARY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROWNSVILLE</u>				c. LENGTH OF STAY IN 1b <u>5/21/49</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BROWNVILLE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ELIZABETH</u> Last <u>HILLIS</u>				4. DATE OF DEATH Month <u>6</u> Day <u>22</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/15/1882</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>22</u> Hours <u>0</u> Min <u>0</u>	IF UNDER 24 HRS Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>St. Mary's Co., MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>CHARLES H HOLBY</u>			
14. MOTHER'S MAIDEN NAME <u>GEORGINA SUE</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			
16. SOCIAL SECURITY NO. <u>no</u>				17. INFORMANT <u>HOSPITAL RECORDS</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MYOCARDIAL DEGENERATION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIO SCLEROSIS</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC BRAIN SYNDROME ASS. WITH CEREBRAL ARTERIO SCLEROSIS</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>none</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that <del>the</del> (this hospital) attended the deceased from <u>5/21/49</u> to <u>7/24/60</u> , that <del>it</del> (we) last saw the deceased alive on <u>7/24/60</u> , and that death occurred at <u>4:15 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>4/16/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>L. BENEDICT M.D.</u>				22d. ADDRESS <u>CROWNVILLE STATE HOSPITAL</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/25/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph</u>		23d. LOCATION (City, town, or county) (State) <u>Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				25a. REC'D BY REGISTRAR <u>[Signature]</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician to the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
TSM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

64156

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> LENGTH OF STAY IN 1b <u>Rt 1, Millersville P.O.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park, Rt. 1, Millersville P. O.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Benfield Rd.</u>				d. STREET ADDRESS <u>Benfield Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Edmond</u> First <u>White</u> Middle <u>Winchester</u> Last				4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jul. 15, 1884</u>		9. AGE (In years last birthday) <u>75</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rtd. Owner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Playground Equipment Md.</u>		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Pere Winchester</u>				14. MOTHER'S MAIDEN NAME <u>Kattie White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr. Edmund W. Winchester</u> Address <u>Box 395 D, Route 1</u> <u>Millersville P.O. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> 4' DUE TO 1. <u>Hypertensive cardio-vascular disease</u> 2. <u>Arteriosclerosis, generalized.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 1959</u> to <u>April 1960</u> that (I) (we) last saw the deceased alive on <u>Feb. 1960</u> , and that death occurred at <u>3 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Francis I. Codd</u>				22b. DATE SIGNED <u>4-13-60</u>		22c. PHYSICIAN'S NAME (Type) <u>Francis I. Codd</u>	
22d. ADDRESS <u>Severna Park, Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/20/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tiekner &amp; Sons - Balto</u>				25a. REC'D BY REGISTRAR DATE <u>APR 19 1960</u>		25b. REGISTRAR'S SIGNATURE <u>Carroll S. Minkes</u>	

17-60

4-1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4162

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

64157

1. PLACE OF DEATH a. COUNTY <u>AA</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN It <u>General</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>AA</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> d. STREET ADDRESS <u>Box 294 Rt 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lola</u> First <u>Jane</u> Middle <u>Worth</u> Last		4. DATE OF DEATH Month <u>4</u> Day <u>29</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 13 1960</u>
9. AGE (In years last birthday) <u>1</u> yrs. <u>4</u> Months <u>9</u> Days <u>1</u> Hours <u>1</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Clyde B. Worth</u>	
14. MOTHER'S MAIDEN NAME <u>Pattie Lee Winn</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>-</u>	
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Clyde B. Worth</u> Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>924.0</u> DUE TO <u>Cisphyxin</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>None</u> DUE TO (c) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>None</u>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Valium (Pentec) fed over infant's face</u>		20c. TIME OF INJURY Month, Day, Year <u>4/29 1960</u> Hour <u>8</u> a. m. <u>4:29</u> p. m. <u>19 60</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Annapolis</u> (County) <u>AA</u> (State) <u>MD</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .	
ACTUAL SIGNATURE <u>E. L. Winkler</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. Winkler</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>4/29/1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 2 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Spring Lawn Cem</u>		22d. LOCATION (City, town, or county) <u>New Paris</u> (State) <u>Ohio</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u> ADDRESS <u>Sons Annapolis Md</u>		24a. REC'D BY REGISTRAR <u>DATE MAY 2 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 and 5 should be forwarded to the Chief Medical Examiner's Office along with item PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.

VS/ATMSE  
PM 7/59

4163  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN 1b <b>DOA</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, list name and address) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Severna Park</b> d. STREET ADDRESS <b>Manhattan Beach</b>	
3. NAME OF DECEASED (Type or print) <b>Blanche YOUNG</b>		4. DATE OF DEATH <b>April 18, 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/12/60</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <b>Annapolis, Md.</b>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James E. Young</b>		14. MOTHER'S MAIDEN NAME <b>Martha Ann Jones</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service)		17. INFORMANT <b>James E. Young, Same as 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Interstitial pneumonitis</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>492X</b> (c) <b>492X</b> (e), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Petty</b>		DATE SIGNED <b>April 19, 1960</b>	
EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/20/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial</b>	22d. LOCATION (City, town, or country) (State) <b>Glen Burnie, Md.</b>
23. FUNERAL DIRECTOR <b>Hopping and Kirkley</b>		24a. REC'D BY REGISTRAR <b>DATE APR 22 '60</b>	
ADDRESS <b>Glen Burnie, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Petty</b>	

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